

SEPTEMBER, 1946

Rhode Island
MEDICAL JOURNAL



Providence Medical Association

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at the Medical Library

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WEDNESDAY, OCTOBER 9

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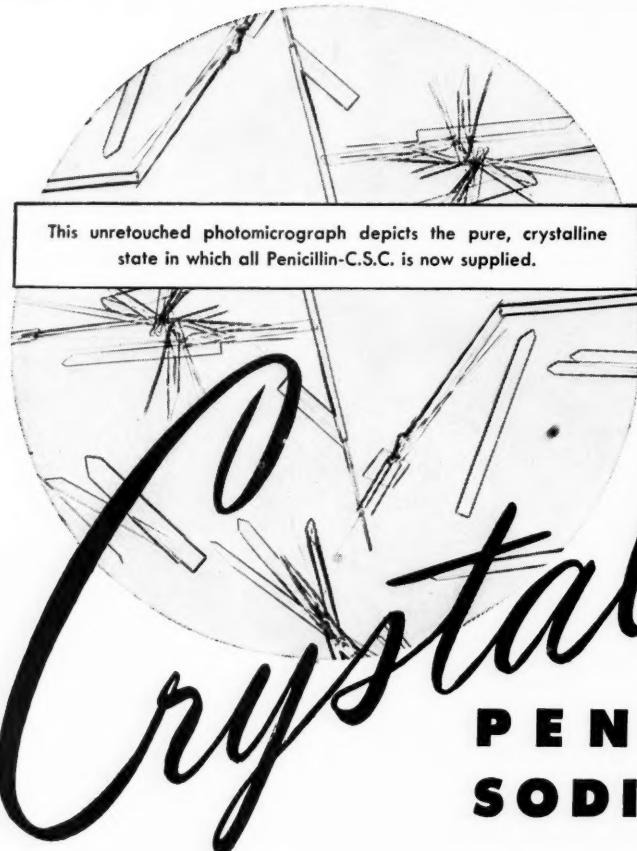
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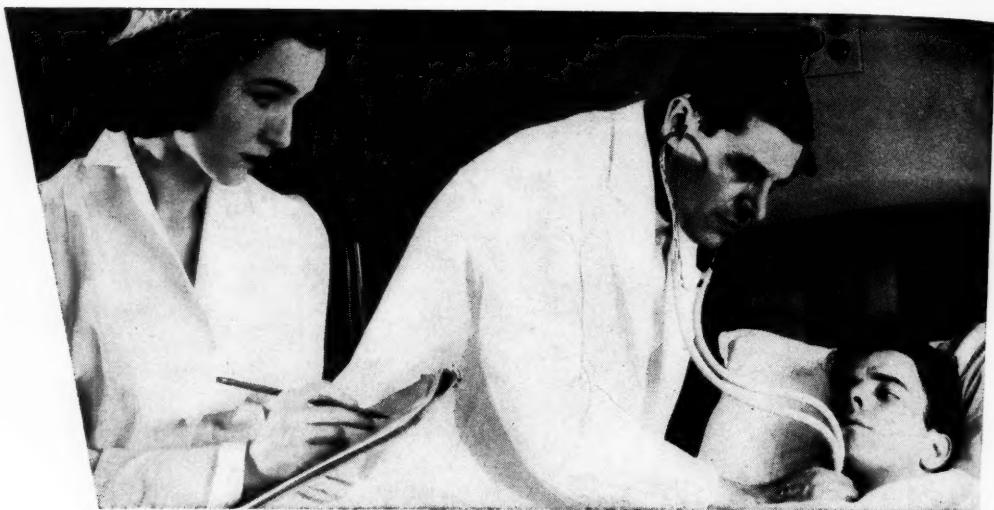
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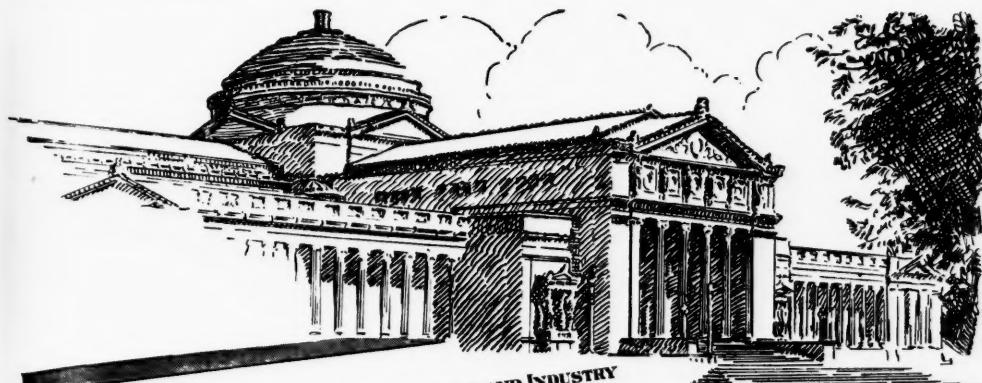
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Mr. C. H. Fleck, President
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August 7, 1946

Dear Mr. Fleck:

Today marks the 10th Anniversary of the Transparent Woman exhibit and since the famous "lady" is making her permanent home in our Medical Section, we feel that the day should not be allowed to pass without some comment.

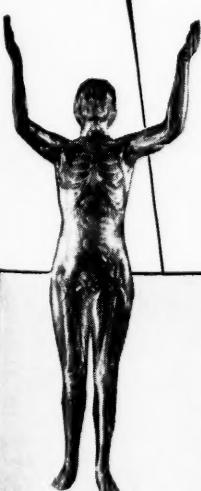
I vividly recall the premier of the Transparent Woman at Rockefeller Center in New York City before a distinguished assembly of physicians, scientists and educators. Its later tour throughout the Nation under the auspices of state and county medical societies and academies of medicine was a significant contribution to public health education. You are to be congratulated not only on your sponsorship of this important and effective exhibit but also on the ethical manner in which it was presented to the laity through the profession.

The Transparent Woman continues to be one of the major centers of interest at the museum. Practically all of the 1,026,250 visitors last year made her acquaintance and preliminary 1946 figures show the attendance running higher.

It is fitting on this 10th Anniversary of the Transparent Woman exhibit to again express our appreciation to you for your active interest in the Medical Section.

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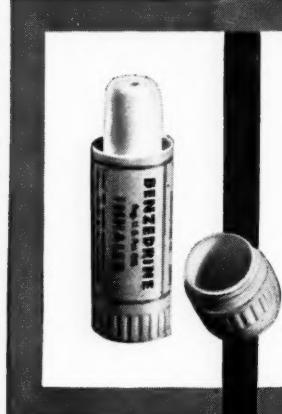
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Feinberg, S. M.: Allergy in Practice,
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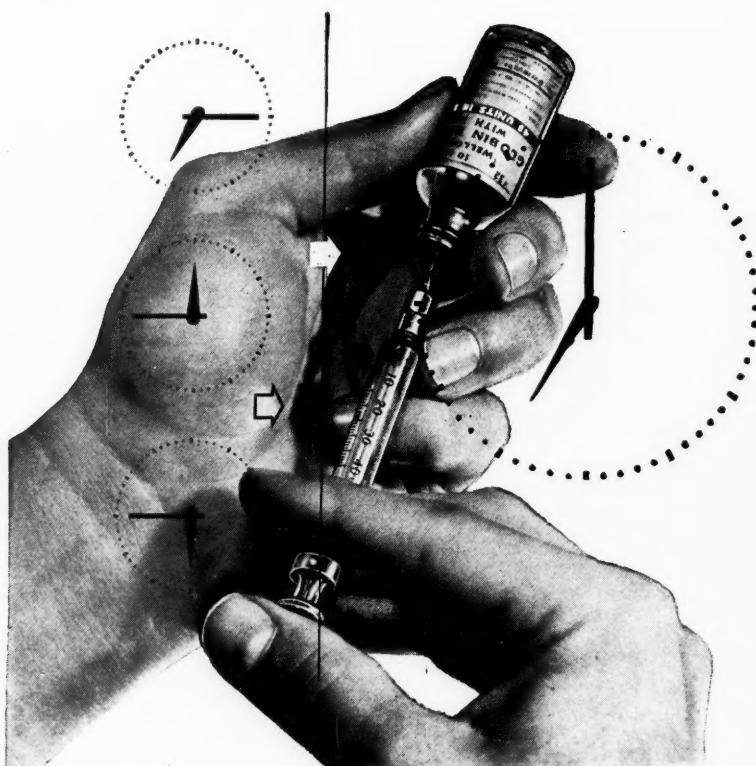
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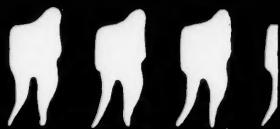


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*Streat, L. P., Beaudet, J. P.: New York State J. Med. 45:2183 (Oct. 15) 1945.



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*N. Y. State Journ. Med. 35 No. 11,590 **Laryngoscope 1935, XLV, No. 2, 149-154

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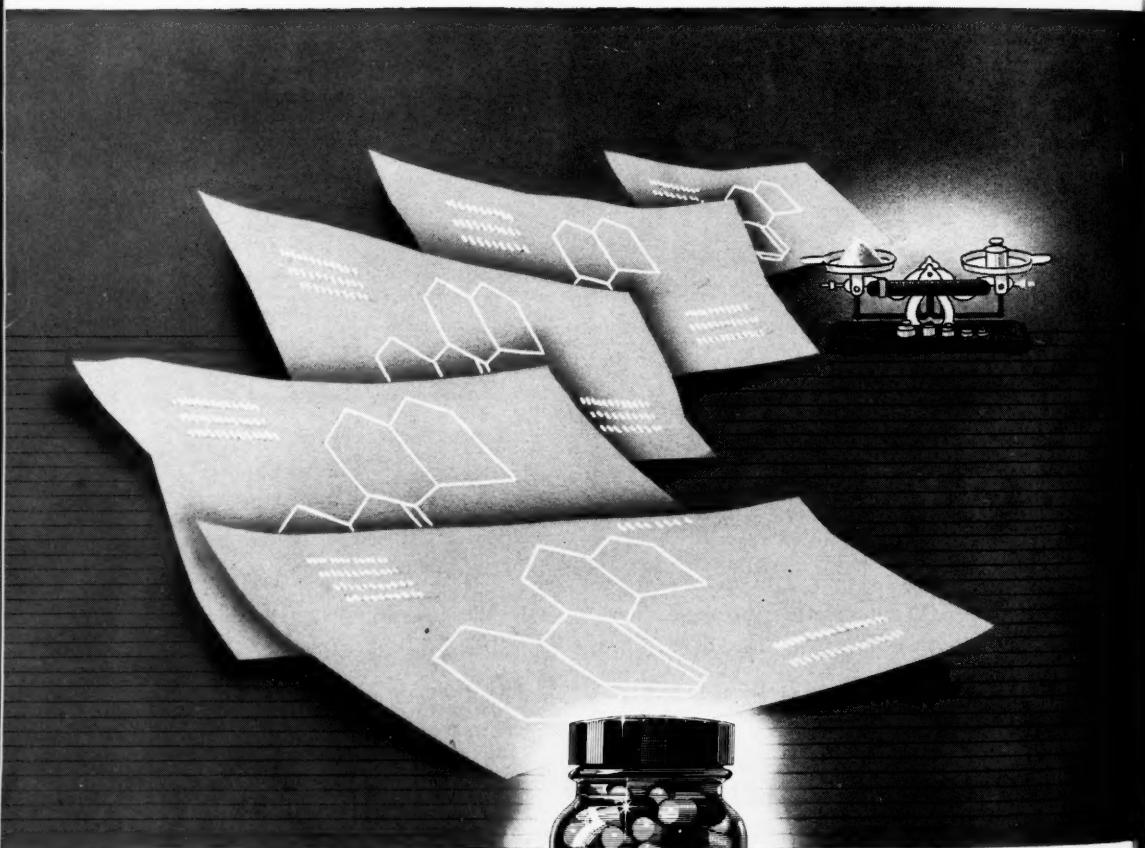
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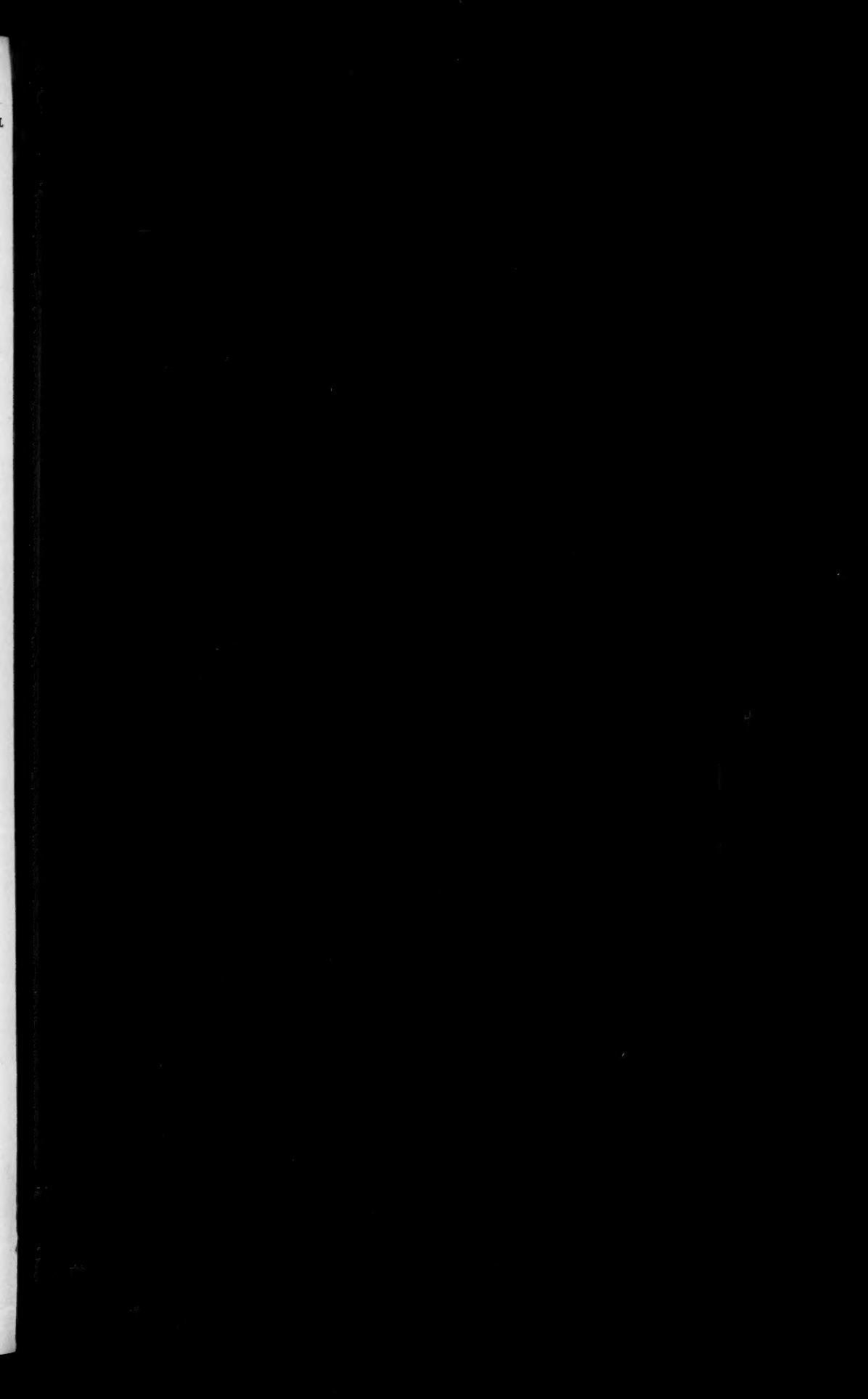


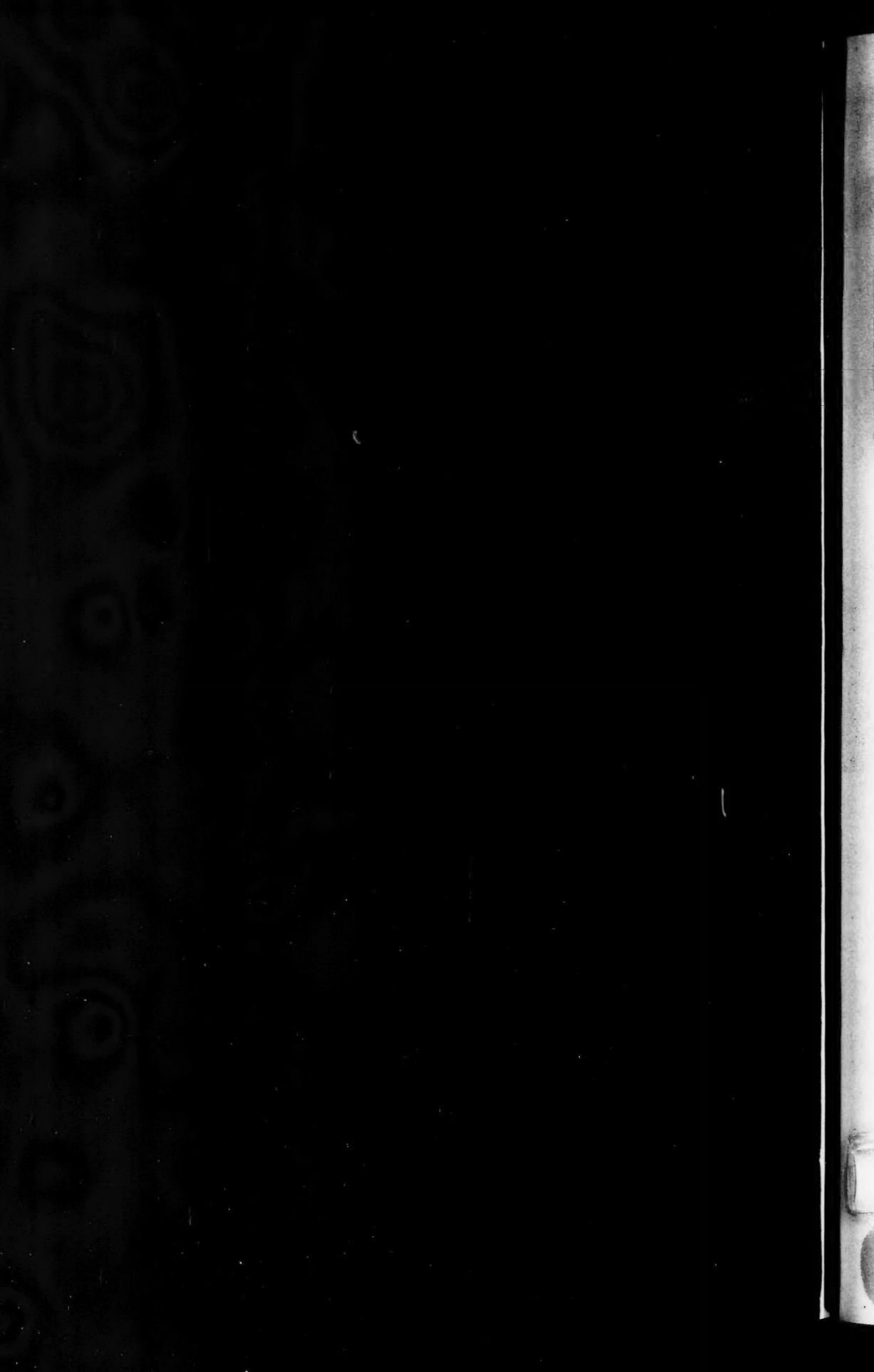
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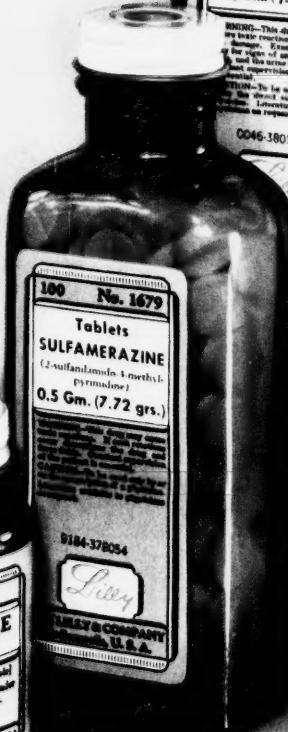
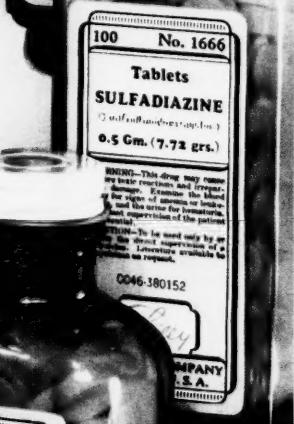
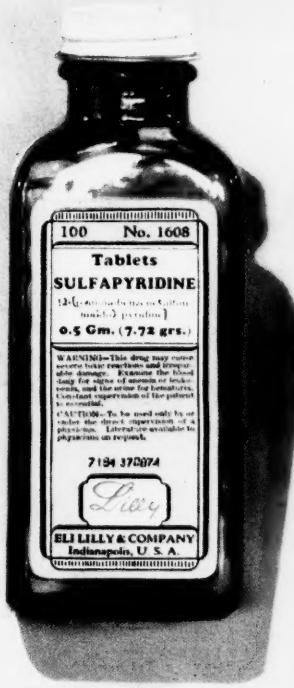
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXIX

SEPTEMBER, 1946

NO. 9

SEVEN YEARS EXPERIENCE IN THE CONVALESCENT CARE OF RHEUMATIC FEVER*

JOHN P. HUBBARD, M.D.

LOUIS A. SIERACKI, M.D.

ISABELLE JORDAN, R.N.

The Authors. John P. Hubbard, M.D., at present conducting a study of child health services under the auspices of the American Academy of Pediatrics; Louis A. Sieracki, M.D., Medical Director, Sharon Sanatorium; Isabelle Jordan, R.N., Superintendent of Nurses, Sharon Sanatorium.

THE present discussion is based upon seven years of experience in convalescent care of rheumatic fever at the Sharon Sanatorium. Upon this background I wish to discuss some of the aspects of convalescent care in hospital, sanatorium or home.

In October 1938 many of us who were dealing with rheumatic fever were much concerned over the lack of facilities for rheumatic children. During the spring months it was not unusual for a large proportion of medical beds in hospital wards to be filled with rheumatic children. They could not be kept indefinitely in beds needed for acute illnesses, but where could they be sent? Available places for rheumatic children were already filled and even had long waiting lists. Therefore, it often happened that while these patients were waiting their turn for suitable placement they were sent home despite the fact they were sick children who should have been kept under medical supervision.

Not only was there a lack of beds for these patients when they were ready for discharge from the acute hospital, but also there was a need for developing methods of preventing respiratory infections which so often precipitate recurrent rheumatic infection during recovery from an acute attack. But how should a child be protected from colds? It was exactly that problem we sought to explore. It appeared a reasonable venture to take children who were in the convalescent stage, place them in a more or less isolated colony in an open-

air environment following the general principles of a tuberculosis regime. That as far as we know, had not been adequately tried out as a method of care for the rheumatic child. About this time there was considerable enthusiasm for sending children south to a warm, balmy atmosphere where there was comparatively little rheumatic fever in the native population. We proposed just the reverse, placing them out-of-doors in the rigorous atmosphere of New England, in an attempt to build up their resistance.

During the first year only children recently recovered from active infection were admitted in order to test the procedure with a cautious beginning. This was thoroughly successful and so subsequently any children needing convalescent care were admitted whether with or without heart disease, with or without active infection. Since we first opened the Sanatorium to rheumatic fever, up until November 1944, there were 201 children admitted. Approximately two-thirds of them were admitted in the active phase of rheumatic infection; about 50% had evidence of heart disease. Patients with heart disease were arbitrarily divided into two categories; (1) mild or moderate, and (2) severe. A history of pericarditis or congestive failure, which may be considered as two of the most severe manifestations of rheumatic heart disease, were chosen as the criteria for classifying a child as having had severe heart disease. No patient was admitted who, at the time of admission, had evidence of either pericarditis or congestive failure, but 8% had been through these serious episodes which are usually associated with an unfavorable prognosis. An attempt was made to select patients who were in the early stages of rheumatic infection, feeling that more could be done for such patients than those with far advanced heart disease.

One of the most conspicuous features of the plan of care developed at Sharon has been keeping the

continued on next page

*Presented at the Annual Dinner of the Children's Heart Association of Rhode Island, at Providence, January 2, 1946.

children in open-air wards both winter and summer. No child with even severe heart disease suffered in any way from being kept outdoors on the coldest days. The Sanatorium which had been a tuberculosis sanatorium, was closed to tuberculosis and turned over entirely to rheumatic fever. A certain amount of remodeling had to be done in order to have open-air porches with the exposure to the South. Glass partitions were set up on these porches to separate the children as a further precaution against cross-infection.

The customary methods of symptomatic treatment were used. Salicylates were given for the relief of arthritic pains, and occasionally for a possible beneficial effect on pericardial or pleural effusions. As the symptoms subsided, the salicylates were gradually reduced and then omitted altogether in order to avoid masking any evidence of active infection. Symptoms and signs of active rheumatic fever were the criteria to determine how long a patient should be confined to bed. These are now generally accepted and may be enumerated as follows: inflammation or pain in one or more joints; chorea; erythema marginata; subcutaneous nodules; evidence of cardiac decompensation; progressive cardiac damage, such as the development of aortic regurgitation in a patient who has had only mitral involvement; pneumonitis; percarditis; rectal temperature over 100° F; elevation of pulse (the sleeping pulse has been recorded regularly and has been particularly helpful); increase in the leukocyte count; increase in the erythrocyte sedimentation rate; anemia; prolongation of the PR interval of the electrocardiogram.

We have followed the generally accepted and fundamental principle of enforcing complete bed rest until there is no evidence of active infection as indicated by the criteria enumerated above. When there were no further signs or symptoms of active infection, the patients were allowed a carefully regulated program of increasing activity, up out of bed and sitting in a chair, walking to the bathroom, out of bed for a period of time which was usually increased one hour a week, participating in the occupational therapy and school groups and then allowed out in the yard, generally after reaching the point of being out of bed six hours daily. This schedule was individualized according to the duration and severity of the disease. A child with no heart disease was allowed to progress more rapidly than a child who had suffered considerable cardiac damage or had been in bed for a longer time.

When patients reached the point of being up all day, they were placed on a full ambulatory regime which included a rest period before and after meals. The cardiac patients were purposely allowed to mix with the non-cardiacs, and emphasis was placed on

an attempt to prevent the cardiaques from developing the psychology of invalidism. No matter how much valvular damage or cardiac enlargement was present, the patient was allowed as much activity as was possible within the limit of dyspnea which was found to be the best guide, easily understood by the patient and by those responsible for his supervision while at the Sanatorium or later after discharge. This policy allowed a much greater degree of freedom than is often recommended. It is based on the observation that it is not so much the degree of cardiac damage that calls for restriction of activity, as it is the presence or absence of active infection.

From the outset, the plan of management has been built upon detailed and persistent efforts to prevent the introduction of respiratory infections or the spread of hemolytic streptococci from the throat of one patient to the throat of another. In the first place, the group has been kept as a pure rheumatic fever colony thus avoiding the possible dangers of a general convalescent home where varied chronic infections may introduce streptococci either directly by spread from one patient to another, or indirectly by carriers among the personnel. No visitors with any infection were allowed. All visitors were urged to refrain from kissing or bending over the children.

Most of the patients remained at the Sanatorium for long enough periods to constitute a significant part of their developmental life; the average stay was eight months. Therefore, facilities for the educational, social and recreational rehabilitation of the patients were considered essential.

School teachers were employed to give individual instruction to the bed patients and group instruction to the ambulatory patients. In nearly every case the child was able to return to the proper school class upon discharge from the Sanatorium.

Medically trained social service workers, preferably experienced in the problems of rheumatic fever, are an essential part of any rheumatic program. Before admission to the Sanatorium a social investigation of the patient's home was made and throughout the period of stay close contact was maintained with the parents. The parents were allowed to visit once a week and with the help of the social worker received consistent and friendly education in the significant features of rheumatic fever, the danger of respiratory infections and the methods of preventing them, the importance of proper hygiene, avoiding over-crowded, over-heated sleeping quarters, and the proper management of heart disease. Thus while the child was at the Sanatorium, his home was being prepared to receive him when he was well enough to return. After discharge the social service worker maintained contact with the family so that a very satisfactory follow-up record was possible.

A full-time, trained occupational therapist provided supervised constructive handiwork for all patients whether ambulatory or confined to bed. Recreational programs were arranged for the ambulatory children without which any group of children will turn to mischief.

Whenever possible all patients were kept at the Sanatorium for at least two months after they reached the point of having full ambulatory activity, or as full as the cardiac status allowed. This period was intended to restore them to robust health before returning home and to prevent the rheumatic recurrences which are so apt to occur following discharge from a hospital or convalescent home.

Rheumatic children are apt to have extensive dental caries. It is uncertain whether this fact has any direct relation to rheumatic fever itself; however, dental care was included as a part of the general care of the patient. Dental facilities were provided in the Sanatorium building so that before discharge the mouth of each patient was clean and free from caries.

When the child was ready for discharge from the Sanatorium he was given an appointment to return to the referring agency or physician. Since most of the patients originated in the rheumatic fever clinic of the Children's Hospital, they returned to this clinic. At the age of twelve years, the upper age limit for the Children's Hospital, they were discharged to the care of an adult clinic or a private physician. A large proportion of them were followed in the cardiac clinic of the Massachusetts General Hospital.

Emphasis has been placed on the incidence of recurrences of rheumatic infection occurring while at the Sanatorium and also following discharge. This may be taken as one of the most valuable criteria in judging any plan of care for rheumatic children. As stated at the outset, one of the main considerations in establishing this group of children in an open-air sanatorium was an attempt to prevent respiratory infection and recurrent rheumatic infection during the period of convalescence. Eight patients (4.8%) had a recurrence while at the Sanatorium. Following discharge, during the periods of follow-up, there were 38 (24.4%) recurrences. There were no fatalities at the Sanatorium. Any patient who had a fulminating, progressive disease or who had developed severe congestive failure was returned to the Children's Hospital where more appropriate attention could be given to a critically sick child. Without attempting at this time an analysis of these figures in comparison with other institutions, it may be said that the incidence of recurrence and the mortality compare very favorably with results for any comparable group.

In the light of these results, certain factors involved in convalescent care may be discussed with particular reference to the child's own home, foster home, sanatorium or convalescent home.

There are obvious advantages to having a child kept in his own home environment during a prolonged period of convalescent care, the most important of which is maintaining his position as an integral member of the family. The extent to which this plan of management is desirable involves such factors as the size of the family, the economic status, the provision of a separate room, adequate nursing care, and the availability of home teaching. Since most of the children developing rheumatic fever come from the lower economic social levels, home care cannot always provide these resources.

Foster home care in certain areas has been developed as a suitable substitute for home care. It is important, however, to bear in mind that if foster home care is to be properly defined, the number of children placed in any one home should not exceed in numbers the limits of an ordinary family. When a foster home takes in ten to fifteen children, particularly if they are placed together in a crowded room or ward, it ceases to be a foster home and should more suitably be classified as a convalescent home.

Any satisfactory plan of management for convalescent care of rheumatic children must take into consideration two major factors: (1) suitable medical care and (2) attention to the development of the child's whole personality during the period of his convalescence. Suitable medical care involves regular attendance by physicians familiar with the characteristics of the disease, adequate nursing care given by personnel also familiar with the peculiarities of rheumatic fever, facilities for routine laboratory procedures including sedimentation rate determinations, provision for the isolation of any patient developing respiratory or other communicable disease, and dental care preferably within the institution. Frequently the periods of the time during which these patients must remain under close medical supervision stretch into many months or even years, constituting a considerable proportion of the child's life. Training and education can not be neglected during these periods. The children must be taught so that he may eventually rejoin his own age group at school; he should be trained in constructive habits, and, for those with severe cardiac damage, taught to remain within the limits of his cardiac reserve. Considering the fact that most rheumatic children come from poor families in crowded quarters of the community, there are very few homes that can afford these essential attributes of adequate care. Even in homes where all these necessary services may

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HEMANGIOMAS

Should treatment be expectant or active?

F. RONCHESE, M.D.

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SHOULD hemangiomas in infants be given active treatment or not? This is a question frequently raised in response to (1) case reports illustrating the spontaneous disappearance of infantile hemangiomas or to (2) articles advising against any form of therapy because of their spontaneous regression within 5 years. Consequently, advocates of active therapy are even under accusation of operating unnecessarily and dangerously.

That vascular tumors may disappear spontaneously is proved beyond a doubt in the papers of Lister³, Hopkins¹, Watson and McCarthy⁴.



Fig. 1 — (left) A doughy, doughnut-shaped, flesh colored tumor below the knee of a 2 weeks old male infant. Because of the location, age and deferred diagnosis, expectant therapy was decided. Six months later the tumor was completely gone leaving only a slightly wrinkled surface. (right) the same infant's leg at 18 months of age.

The nature of this tumor remains a puzzle, but what tumor, other than a vascular one, could have disappeared spontaneously?

The case illustrated in figure 1 is a further demonstration of this fact. The disappearance may be tentatively explained as a sudden severance of blood supply to that area. It is evident, however, that not "every such tumor" disappears spontaneously, otherwise none at all would be seen in the adult. Moreover, according to my tabulation, the percentage of hemangiomas noted in the adult is far from small.

Everybody knows that warts may disappear spontaneously overnight, that psoriasis may disappear suddenly without treatment, that the infant may outgrow his atopic eczema. The bald spots of alopecia areata may not fill up according to the general rule within a few months. However, who can foresee which warts, psoriasis, or atopic eczema will disappear in later years and which will not; which case of alopecia areata will persist indefinitely or turn to alopecia totalis?

One reason for the small number of hemangiomas seen in adults may be that the great majority of them receive treatment in earlier years particularly in countries providing adequate care of their children. Following out this argument, in countries with fewer clinical facilities more hemangiomas should be seen in adults*.

Since, in my own experience, I have treated, or seen treated, practically all of the infantile hemangiomas, I had no personal recollection of any incidence of spontaneous disappearance. However, on investigating the records of 347 hemangiomas in children under 3 years of age, I found 10 cases in which no treatment had been administered. Unfortunately only 1 of these patients could be reached

*Dr. Reiss of New York, with 19 years experience in China, informs me that he has not noticed any difference in the number of hemangiomas in adults in that country.

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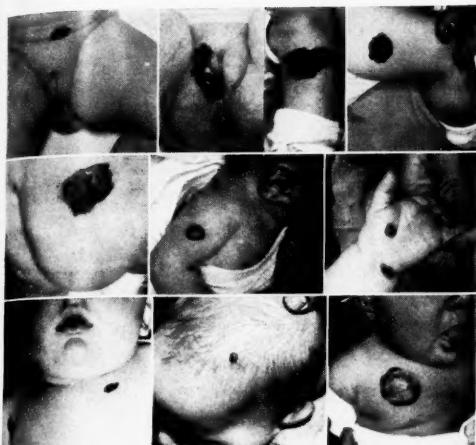


Fig. 2—Strawberry naevi suitable for expectant therapy because of size and location. If they have not disappeared after 5 years they can be easily removed by surgery.



Fig. 3—Cavernous naevi unsuitable for 5 years expectant therapy because of facial location. (below) Good result after insertion of 2—0.25 millicuries radon implants.

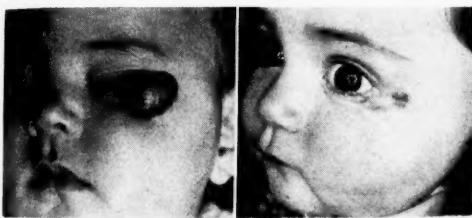


Fig. 4—Cavernous hemangioma before and after insertion of 4—0.25 millicuries radon implants. No radiation sequelae.

Should this hemangioma fail to disappear spontaneously, it will take a very skilled plastic surgeon to correct the deformity.

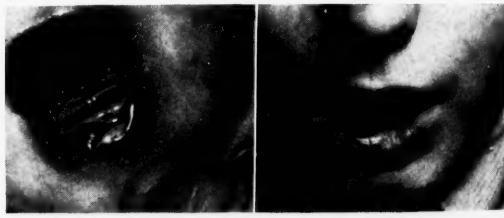


Fig. 5—Cavernous hemangioma at 6 weeks of age and again at 12 years of age, after treatment with surface radium (50 milligrammes tube, 1 cm from skin, 3 hours, 10 exposures at 8 weeks intervals). The lip appears perfectly normal.

However, according to Lister, the possibility always exists that the therapy has nothing to do with the cure.



Fig. 6—Cavernous and strawberry naevi that are particularly unsuitable for expectant therapy because of their small size and facial location.

Why wait 5 years for spontaneous disappearance, when one or two, properly done, carbon dioxide applications will effect a cure in a few weeks with little (bottom left) or no trace at all (bottom right)?

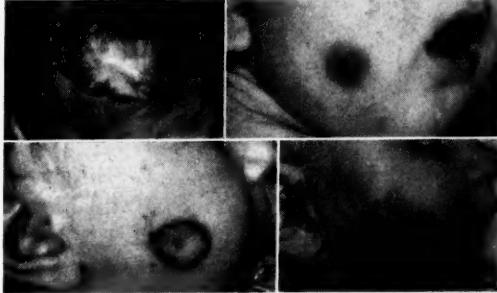


Fig. 7—Partial healing of cavernous hemangiomas after rupture and secondary infection. This therapy, provided by nature, is easier to explain than the spontaneous disappearance without rupture.

A disfiguring location contra-indicating expectant therapy.

for follow-up; in his case a hemangioma of the shoulder had disappeared. But then, on further investigation among other patients of mine and their friends I found 6 cases of spontaneous regression or disappearance, the information being furnished by the mothers.

It is now my intention to leave untreated all hemangiomas located on areas usually covered by clothes or bathing suits, or in other areas when they may be surgically removed later, should they fail to disappear spontaneously, unless parents insist on treatment.

The question of whether or not to treat hemangiomas is particularly disturbing to the dermatologist who is called on to decide what to do. I am sure that no one would choose the hard way.

Lister³ was the first to make a systematic study of this subject. He made an extensive survey of the literature and then cited his own 7 years of experience with 77 children and 93 naevi. All of these naevi disappeared within 5 years, without treatment.

To this excellent paper, however, some exceptions may be taken. For instance, strawberry naevi are considered synonymous with cavernous nevi. In our textbooks strawberry naevi are described as superficial vascular naevi, usually small and sharply outlined, always slightly elevated. The suggestion of lobulation produces the appearance of a strawberry (fig. 2 and 9).

Cavernous naevi, on the other hand, are described as of any size—pin head, pea, silver dollar, palm, etc.—and as deep, spongy and cavernous (fig. 3-4-5-9-11).

Moreover, the distinction Lister makes between rapidly growing and non-rapidly growing tumors as a prognostic sign influencing the decision for or against treatment, is puzzling. Quite paradoxically, the rapidly-growing are those expected to disappear spontaneously; treatment was recommended for the not-rapidly-growing. In my experience I have never been confronted with such a problem, nor have I heard of it. All infantile hemangiomas appeared at birth or soon after, grew to various sizes, but usually did not progress after the first

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Fig. 8—(A) Cavernous hemangioma of the auricle in a baby girl. Surface radium (50 milligramms tube, 1 cm from skin, 3 hours, 4 exposures at 8 weeks intervals) improved the condition considerably. Since in adult life it would be concealed by the patient's hair, this might be considered a case suitable for expectant therapy. However, should spontaneous disappearance fail to occur, a plastic surgeon would have to make a new ear.

(B) This boy's hemangioma would be suitable for expectant therapy. His sister, now aged four, had 3 small hemangiomas which disappeared spontaneously. However, in this boy no long hair will cover the lesion, it may be damaged during hair-cutting, and interfere with glasses if they must be worn. One, or perhaps two, carbon dioxide snow treatments takes care of such a case in a few weeks. It would be nonsense to wait 5 years for a spontaneous disappearance.



Fig. 9—A sample of hemangiomas that did not disappear.

(A) A naevus flammeus of the scalp turning a cavernous, easily treated by desiccation. (B) A typical strawberry naevus on the thigh of a 16 year old girl. A considerable deformity for a girl, unsatisfactorily treated with carbon dioxide snow and sclerosing fluids. A big problem for the plastic surgeon. (C) A strawberry and cavernous hemangioma of the cheek satisfactorily treated by desiccation.

(D) A mixture of flammeous, strawberry and cavernous hemangiomas of the nose about which the adviser of expectant therapy cannot brag.



Fig. 10—A very rare vascular anomaly. Congenital, symmetrical, superficial capillary telangiectases.

TABLE I
Hemangiomas observed in the last 15 years

	under 3 years	from 3 to 12	over 12
R. I. Hosp. Skin O.P.D.	49	3	2
R. I. Hosp. Tumor Clinic	78	13	36
In my office	220		16
Total	347	16	54

The adult cases of the Tumor Clinic include 1 hemangioma of muscle of arm, 5 of tongue, 1 of palate and 5 typical strawberry. Not included among the non-disappearing are the very common spider naevi, the frequently seen port wine-like hemangioma of palms and soles, known as "red palms" or Lane's disease, connected with several internal diseases but nothing more than a naevus, and the very rare congenital symmetrical superficial capillary telangiectases (fig. 10).



Fig. 11—No dermatologist would be enthusiastic about assuming responsibility for this case. In a discussion of spontaneous disappearance of infantile hemangiomas (1) a similar case was described which disappeared completely without treatment.

This case received surface radium (with a brass shield on the eyeball, although the cornea is known not to be radium sensitive [McKee]), carbon dioxide snow and sclerosing injections. There is now considerable scarring but no defect in appearance or function of the eye.

year and all were suitable for either active or expectant treatment.

The main point of the subject is that "not all" hemangiomas disappear spontaneously and the decision for or against, is to be based on the size and location of the tumor.

Small ones, located, for instance on the head (fig. 6) very disfiguring, but at the same time easily, quickly and satisfactorily treated, should receive treatment. There is no reason to let the parents suffer while waiting the 5 years and take a chance, even if a small one, of a permanent disfigurement.

Those located in areas covered, for instance, by a bathing suit, or hair (fig. 2) and easily treated surgically later, should they not disappear spontaneously, could be left untreated.

Text books of dermatology discuss the treatment of hemangiomas but barely mention spontaneous disappearance. While this implies that authorities prefer active to expectant therapy, the latter should be discussed more adequately and more comprehensive detailed directions given for the management of individual cases.

Summary

The question of treating or not treating infantile hemangiomas, in view of the fact that the majority of them disappear spontaneously, is reviewed and discussed.

Because not all hemangiomas disappear, as proved by their occurrence in adult life, and because with proper treatment the risk involved is very small and the sequelae inconsequential, it is advisable to treat the majority of them, leaving untreated only those which, for size and location, are suitable for later surgical removal, should they not disappear.

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DIETHYLSILBESTROL IN THE PREVENTION OF ORCHITIS FOLLOWING MUMPS

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It was the writer's privilege to observe and study a sizable series of cases of adult mumps while on active duty with the Army. It became increasingly apparent that mumps was one of the most common of the contagious diseases in the Army; the most frequent complication of mumps being orchitis with an incidence of between 16 per cent and 30 per cent. The seriousness of orchitis can well be appreciated when one recalls that about 50 per cent of testicles so involved undergo atrophy. An attempt was made to prevent the occurrence of this unfortunate and debilitating complication.

It has been shown that testicular activity may be depressed by the administration of diethylstilbestrol. The incidence of orchitis is low in pre-adolescents with mumps. The writer postulated that this low incidence in pre-adolescents was due to minimal testicular activity and attempted to simulate this state by the administration of diethylstilbestrol. This was carried out in 77 patients ranging from 18 to 34 years of age. No toxic symptoms or side effects were observed in this series which could be attributed to diethylstilbestrol.

Method

The first patients to be treated in this manner received one milligram of diethylstilbestrol three times a day for five days. Three patients of this group developed orchitis and they comprise the only failures in this series of 77 cases. It was felt that perhaps the failures were due to the fact that the dosage was inadequate. Consequently, the dosage was changed to provide each patient with four milligrams a day for seven days.

Since the institution of the increased dose, there were no cases of orchitis except in patients who were admitted to the hospital with the diagnosis of orchitis.

The routine treatment for mumps varied from that commonly employed only by the use of diethylstilbestrol. It consisted of the following measures:

1. Bed rest with lavatory privileges for six or seven days, depending on the extent of parotid or submaxillary swelling.

2. Aspirin, grain ten, for pain when necessary.
3. Soft diet for the first two or three days.
4. Fluids freely.
5. Diethylstilbestrol, one milligram four times a day, for the first seven days. Regardless of the time of admission, the patient received the full dose for that day.

Owing to a temporary shortage of diethylstilbestrol, therapy was interrupted in 17 patients with the result that five cases of orchitis developed. These patients received none of the drug for an average period of 2½ days. These patients were omitted from the series and their data are shown in Table II.

We observed 168 patients who did not receive diethylstilbestrol. The incidence of orchitis in relation to time was broken down into two main groups:

1. Those patients who were admitted to the hospital with orchitis or developed orchitis within the first 24 hours after hospitalization, i.e. "Admission Orchitis."
2. Those cases which developed orchitis in the hospital after the initial 24-hour interval, i.e. "Hospital Orchitis."
 - a. One case was classified as "doubtful" since the patient complained of pain in the right testis associated with tenderness upon admission to the hospital. He subsequently developed an orchitis on the left side.

TABLE I

	<i>Untreated</i>			<i>Treated with Diethylstilbestrol</i>		
	Total Cases	% of Orchitis	Total Cases	% of Orchitis		
1. Admission Orchitis	15	8.9	10	13.0		
2. Hospital Orchitis	28	16.6	3	3.9		

1. Admission Orchitis	10	13.0
2. Hospital Orchitis	3	3.9
2. (a) Doubtful type of Orchitis	1	1.3

TABLE II

Treatment with Diethylstilbestrol Interrupted

	Total Cases	% of Orchitis
1. Admission Orchitis	17	53.3
2. Hospital Orchitis	5	29.8

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WATERHOUSE FRIDERICHSEN SYNDROME

LEWIS ABRAMSON, M.D. AND FRANK MAYNER, M.D.

The Authors: Lewis Abramson, M.D., Physician, Medical Service, and Frank Mayner, M.D., Pathologist, of the Newport Hospital, Newport, Rhode Island.

THE Waterhouse Friderichsen Syndrome is a rather rare condition and up to the present time there are only a few more than one hundred reported cases.

Lindsay, Rice, Selinger and Robins¹, Cary², Michael and Jacobus³, Levinson⁴, Kunstadter⁵, McLean and Caffey⁶, McNamara and Cornell⁷, Drummond and Took⁸, Aegeerter⁹, Kvedar¹⁰, and Monfort and Mehrling¹¹ are recent authors who review the literature, give the history, clinical findings and pathology of the Waterhouse Friderichsen syndrome.

The usual clinical picture is that of a sudden onset in an otherwise normal child, of headache, malaise, anorexia, elevation of temperature, vomiting and diarrhea. Ten to twelve hours later marked cyanosis of the skin develops, followed shortly by petechial mottling action of the skin which may be cold. Convulsions, weak, irregular heart and peripheral collapse occur usually within forty-eight hours. The age is usually between six months and nine years, with 70 per cent under two years. The number of male and female patients is the same. Smears taken from the petechial hemorrhages, stained with Gram's Stain, may reveal gram negative intracellular diplococci. The blood count usually shows a polymorphonuclear leucocytosis. The spinal fluid examination is not consistent. The condition is invariably fatal, although Carey² reports a case with recovery. Treatment consists of the administration of the sulfonamides, epinephrin and desoxycorticosterone. The etiological agent appears to be an overwhelming septicemia of either meningococcus (most common), pneumococcus, staphylococcus, streptococcus, hemophilus influenza and Neissera flavus. The pathology consists of extensive bilateral, adrenal hemorrhage, probably due to either the action of a toxin or venous thrombosis.

The authors had the opportunity of observing the following case at the Newport Hospital:

A twelve year old native born girl was first taken ill at school about noon the day before admission. She had some moderate headache and felt weak and nauseated. She came home alone and went to bed. About four p. m. she began to vomit and she looked greenish in color. Vomiting was not projectile and contained some particles of food but no blood or unusual material.

She continued to vomit and to complain of severe weakness but the headache was not very great. It was felt she might be observed for a while and the orders were nothing by mouth.

At eleven p. m. she had a fine rash which was described as something like scarlet fever.

At four a. m. the family called to say they thought she was dying. She was hospitalized at once.

At hospital oxygen was started and she was given a plasma infusion. At that time her skin was covered with purple petechiae and she was not responsive. She was in circulatory collapse and looked moribund. She died shortly after.

Past history revealed that she was a congenital quadriplegic and had attained sixth grade parochial school with difficulty. Her posture was always poor and dental caries was pronounced. A blood phosphorus study was normal. She had had no serious illnesses.

Physical examination showed no stiff neck and when done at hospital she was moribund. Heart sounds were of fair quality and there were no murmurs. Pulse rate was 150. Temperature was 106°. Respirations were 60 and shallow.

At death she was in complete peripheral vascular collapse.

An autopsy was performed one hour post mortem and only the positive findings will be mentioned.

External Examination: The body is that of a developing, white girl, appearing approximately the stated age of eleven years. Slight shortening of the left leg is present. The skin throughout the body, including the face, contains many petechial and other larger confluent hemorrhages. Several of these are cut into; a smear made and stained with the Gram's Stain shows occasional polymorphonuclear leucocytes, containing intra-

continued on next page

cellular Gram-negative biscuit-shaped diplococci.

Adrenal glands: Both adrenal glands are normal in size. They are very dark red in color and completely hemorrhagic and necrotic. No viable adrenal tissue is visible.

Brain: The usual incision is made and a segment of calvarium is removed. The sub-arachnoid areas are slightly dull in appearance and contain a milky-like fluid which when smeared on a slide shows the presence of many polymorphonuclear leucocytes but no organisms can be found.

MICROSCOPIC FINDINGS

Adrenal glands: Sections show complete necrosis and marked degree of hemorrhage due to extravasated red blood cells throughout all the sections, practically no viable adrenal tissue is left including cortex and medullary zones. The hemorrhage likewise extends beyond the capsule of the adrenal gland.

Brain: The meninges are thickened and infiltrated with many leucocytes, the majority of which consist of polymorphonuclear leucocytes. A rare mononuclear cell is likewise present. In the area of the fourth ventricle through the medulla oblongata, the blood vessels just beneath the ependyma likewise show peri-vascular infiltration. The gray and white matter is microscopically negative.

The liver, spleen and kidney show slight congestion.

ANATOMICAL FINDINGS

1. Hemorrhage of adrenal glands, bilateral (so-called Waterhouse-Friderichsen syndrome).
2. Meningococcic meningitis.
3. Shortening of the left leg.

SUMMARY

The clinical and pathological features of Waterhouse-Friderichsen syndrome have been reviewed and one more case has been added to the literature.

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CONVALESCENT CARE OF RHEUMATIC FEVER

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be provided, the advantages of keeping the child in his own home should be balanced against the advantages of group management where the child is not singled out as an invalid but rather is more apt to consider himself no different from his fellows. At home he looks through his window and sees his friends going to school; when one of a group his friends are in the adjoining beds.

In conclusion it is fair to state that the results of this experience in the convalescent management of children with rheumatic fever demonstrate that an open-air sanatorium may be not only satisfactory but advantageous. When due consideration is given to the principles discussed about, it provides relative freedom from recurrent infection, adequate facilities for medical supervision and training in citizenship for the rheumatic fever child.

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"WITHOUT REFLECTION"

"It is contemplated that this General State Hospital would become the State's leading Medical Center, a center of research, a center available to the medical and nursing professions of the State, whereby members of the medical profession, particularly, could be kept up to date with respect to the rapid development in modern medicine, especially in the fields of bio-chemistry and nutrition.

"Without reflection upon individual members of the medical profession, experience of recent years shows that a center of research and information would be invaluable when such epoch-making drugs as the sulfa drugs and penicillin are developed. I am reliably advised that there was not one single physician in Rhode Island in the beginning, professionally capable to deal with penicillin and its marvelous potentialities. Only a few medical schools today give courses on the all-important subject of scientific dietetics and nutrition. Many doctors engaged in medical practice or attached to hospitals know less about the science of dietetics and nutrition than the professional dietitians in the kitchens of our hospitals."

CLEMENS J. FRANCE, Director, Rhode Island Department of Social Welfare, in his Eleventh Annual Report to the Governor and General Assembly, and to the interested public, submitted July, 1946.

The quoted abstracts from Mr. France's report to the Governor, the General Assembly, and the

public generally, noted above, illustrate in clear fashion some of the loose thinking that is allowed to find its way into print in governmental reports. Mr. France has indeed spoken "without reflection". He may envision a General State Hospital at Howard that would constitute, as he says, "a State medical and clinical center, such as for example, the Medical Center established by the Mayo Brothers in Rochester, Minnesota, or the Lahey Clinic and Medical Center in Boston", and we will allow him to dream. Personally, we will settle, for the present at least, for the fulfillment of the recommendations of the non-partisan State Commission on Public Welfare Institutions, made in 1943, that there be a "development in staff, accommodations and equipment which will make this hospital a well-equipped and up-to-date institution capable of providing the best possible care of patients with acute and chronic disease", and that "the staff should be organized as is that of any general hospital with regular services and a group of visiting physicians and surgeons on active duty", thus "to allow the hospital to receive recognition from the American Medical Association and the American College of Surgeons, a fact which will assure a much better group of internes and residents than can otherwise be obtained." When that is done the State Hospital will make the first long step towards reaching comparable high standards of hospital and

continued on next page

medical care now provided in the outstanding private hospitals of the State.

But when Mr. France goes on record with the statement that there was not one single physician in *Rhode Island* in the beginning, professionally capable to deal with penicillin, he speaks poorly advised, and with little or no knowledge of the practical application by the physician of the results of scientific research. His implications are far reaching, and they might readily be dismissed on the basis of what is freely asserted is freely denied, were it not for the fact that Mr. France, as a public servant, has neither justification nor authority for his indictment of the medical profession of this State. When he states he speaks "without reflection upon individual members of the medical profession" he very apparently tries to soften his blow at all the doctors.

Since Mr. France cites penicillin as an example he warrants advice on the allocation and clinical use of this drug. Like any new discovery to come out of the research laboratory, penicillin was subject to close control and much selected experimentation before it was allocated to physicians, first for use in the hospital, and later for general use. Not even Mr. France's proposed General State Hospital would have had any freer access to the drug, nor would its staff been in any better position to explain its method of administration or clinical uses, than were the local private hospitals and physicians.

Penicillin from the beginning was under the supervision of the Committee on Chemotherapeutic and Other Agents of the National Research Council under the chairmanship of Dr. Chester S. Keefer of Boston. Carefully controlled clinical studies to investigate the value of Penicillin in various infections were conducted by a large number of accredited investigators under the supervision of this Committee, and the results obtained in this cooperative investigation were collated and analyzed for the information and the education of physicians everywhere.

The original report of the Committee, analyzing 500 cases it had approved for treatment with penicillin, was published in late August, 1943. Earlier in that same month the drug was used at the Rhode Island hospital. And in April, 1944, at the regular scientific meeting of the Providence Medical Association, thirteen Providence physicians presented reports on penicillin-treated cases in four of the hospitals in Providence, for the information of their colleagues.

And all this was done, as Mr. France apparently was not advised, at a time when the National Research Council was releasing very little of the drug, and then only for experimental studies in selected cases. Most of the very limited supply of penicillin

went to the armed forces for use in the treatment of battle casualties.

Through scientific medical publications, medical assemblies and hospital staff meetings physicians in general were well acquainted with the clinical uses and administration of the drug by the time it was available in quantity sufficient for the wider allocation of it for civilian illnesses. The same situation prevailed in the case of the sulfa drugs.

When Mr. France discusses diet and nutrition he falls into a parallel error in judgment, for he fails to realize the difference between the need and application of diets as determined by the physician for his patients, and the technical procedures involved in the makeup of the diets as carried out by the professional dietitian.

To paraphrase Mr. France's words, it would appear that some authorities engaged in health and welfare work or attached to governmental social welfare agencies know less about the necessity of long experimental studies and the application of the results of scientific research than the novice social worker in the field.

HARD TO DIGEST

We have often wondered how some of our associates get their vast extent of therapeutic knowledge — so far beyond our own. Really, the answer is simple. They read the Reader's Digest, which we dislike and therefore neglect. The Professor of Therapeutics in this medical school for the multitude is Paul deKruif. Despite his authoritative tone we understand that he is not an M.D.

The last description of Utopian medicine which Dr. deKruif has contributed is an article on Demerol, synthetic substitute for morphine put out by the Winthrop Chemical Co. We will list under our own numbers some of the doctor's statements.

The text for his talk is placed as a heading and reads, . . .¹"The pain fighting power of Demerol is as miraculous as that of morphine—²without the opiates' danger of addiction".³He tells of men hurt by a hot beam on their foreheads but not minding it. A man with kidney colic smiled. He no longer minded the pain. A hysterical woman smiled with her labor pains. "I don't seem to mind them. This medicine makes me brave." We gather from the article that having received Demerol all patients are euphoric while still in pain.

¹In the whole Digest article only two bad effects of Demerol are suggested. It might mask the symptoms of appendicitis and large doses are dangerous; and the latter statement can be truthfully made of practically any drug in the pharmacopeia.

We have before us a booklet on Demerol sent out by the manufacturers. Now it is hard to blame a firm for being enthusiastic about their own products. We expect this in all modern advertising. But consider their restraint on the points taken up

continued on page 668

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DIVISION OF MEDICAL SCIENCES

COMMITTEE ON CHEMOTHERAPY

August 23, 1946

Dr. Peter P. Chase
122 Waterman Street
Providence, Rhode Island

Dear Dr. Chase:

I have before me the letter from ...
... under date of the 9th of August in which the statement was made that a public official in a formal report made the following statement: "I am reliably advised that there was not one single physician in Rhode Island in the beginning, professionally capable to deal with penicillin and its marvelous potentialities".

There never was any question in the minds of the Committee on Chemotherapeutic and Other Agents about sending penicillin to Rhode Island physicians once it became available to our Committee for clinical investigation and at a time when individual physicians in the United States were included in the research program.

According to our records, the first case was treated in August, 1943. This was one month after penicillin had been placed under allocation by the War Production Board and one month after individual physicians throughout the country were included in the research program. The case was that of a patient with osteomyelitis under the care of Dr. Elihu Wing, and according to the report the results were highly successful. To repeat, we never had any doubt concerning the capabilities of Rhode Island physicians in using penicillin under our program.

Sincerely yours

Chester S. Keefer, M.D.

/s

HARD TO DIGEST
concluded from page 666

by our chronicler of miracles. Here are the firm's modest statements . . . ¹The analgesic power of Demerol ranks between morphine and codein. (*most of the profession know that codein is a mighty weak pain killer. Ed.*)

²It carries considerable less risk of addiction than that inherent in morphine. ³The incidence of euphoria in presence of pain is about 10%. ⁴Where the Digest can find only two moderately adverse effects from the use of the drug the manufacturers frankly admit several; thus: Dizziness is a common side effect. Nausea and vomiting occur sometimes. Extreme weakness, syncope, profuse perspiration may occur. Significant side effects have been noted in 25% of cases.

The Winthrop Chemical Company have issued a frank, proper report on what is presumably a valuable drug. In marked contrast is the sensational Digest article, wickedly designed to delude an ignorant public. Who could be in a better position for an unbiased estimate of Demerol than H. J. Anslinger, Commissioner of Narcotics, Washington, D. C.? These are his conclusions in a letter to the Journal of the American Medical Association.

"... I fear a wave of Demerol addiction if physicians who read this article believe what I consider the reckless and dangerous statements made by deKruif that the drug is free from addiction properties. . . . Had this article been prepared on a strictly scientific basis it would have sounded a strong warning about the danger of addiction. Our files contain numerous cases of addiction involving the use of Demerol. I cannot too strongly warn the members of your Association about the danger of addiction to Demerol."

Meanwhile physicians are already being pestered by patients who feel that their sufferings from arthritis, sick headache, etc., should be alleviated by the "harmless" Demerol.

If the statements made in the magazine article were printed on the label under which the article is sold the Federal government would intervene. But the rule of *caveat emptor* apparently still holds for "popular articles."

ETHER CENTENNIAL

On October 15, 16 and 17, Boston celebrates the Centennial of the Discovery of Surgical Anesthesia with luncheons and dinners, clinics at the hospitals, orations by notable guests and eulogies on Dr. William Thomas Green Morton; for on October 16, 1846, Dr. Morton first demonstrated the benefit of surgical anesthesia at the Massachusetts General Hospital in Boston. On that day Dr. Morton administered ether by inhalation while Dr. John Collins Warren did an operation for a vascular tumor of the neck. A few days later Morton again

administered ether while Dr. Warren did a major operation, a thigh amputation. These were memorable operations because the patients did not cry out with pain, did not struggle against the restraining bands, but slept peacefully while the operation was being performed and awoke to testify that they had felt no pain from the surgeon's knife.

News of this event spread with unparalleled rapidity throughout the world; by the end of the year anesthesia was being employed in London, in Paris and elsewhere in Europe; within six months it was known and practiced throughout the civilized world. There could be no doubt that Dr. Morton, by overcoming pain in surgery, had performed an inestimable service to humanity. It was foreordained that this tremendous event should be fittingly commemorated now, and in Boston.

No one can doubt the importance of Morton's successful demonstration of the possibility of painless surgery for if it had failed the use of anesthesia in surgery and in childbirth would have been postponed for years, perhaps forever. But there are many mistaken ideas about what Morton discovered and what he demonstrated. Morton did not discover ether; it was known to the alchemists in medieval times. He was not the first to use ether by inhalation; it was used by Dr. Warren in his routine practice. He was not the first to suggest the possibility of relief of pain; Humphrey Davy had predicted that nitrous oxid might relieve the pain of surgical operations.

Morton did discover that inhalation of ether vapor could render a subject incapable of experiencing pain during a surgical operation and that the patient would safely recover. He found that the ether used must be pure and that the vapor must be diluted with a large proportion of atmospheric air. Morton discovered that pain in surgery could be relieved with safety. He made the revolutionary decision that pain should be relieved and set to work diligently to bring about that desired end.

Others sought to prove that they had used ether for pain relief before Morton demonstrated its practicability and safety, and their claims may well be true. But what state of mind led them to conceal a discovery so obviously needed for the benefit of humanity? They may have failed to appreciate the grandeur of the discovery; they may have been selfishly callous to widespread suffering among other people. William Morton realized the importance of his discovery. He sacrificed fortune, health and life to hasten its universal adoption.

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*Program of the Fifth Annual Session, Sponsored by
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Boston, October 30 and 31, 1946*

OCTOBER 30

- 10:00 THE NATURAL COURSE OF HYPERTENSION James Berdley, M.D.
(Johns Hopkins Hospital, Baltimore)
- 10:30 TIME OF ELECTION FOR ABDOMINAL SURGERY . . . Edward J. Donovan, M.D.
(College of Physicians and Surgeons, New York)
- 11:15 PART I. 200 OBSTETRICAL CONSULTATIONS IN PRIVATE PRACTICE—A review of the commoner complications which both the general practitioner and the obstetrician confront. Nicholson J. Eastman, M.D.
(School of Medicine, Johns Hopkins University)
- 11:45 TROPICAL DISEASES Joseph Hayman, M.D.
(School of Medicine, Western Reserve University, Cleveland)
- 12:15 (Luncheon meeting at Hotel Bradford)
MEDICAL ASPECT OF CARE OF CANADIAN VETERANS, W. P. Warner, M.D.
(Director General, Department of Veterans Affairs, Canada)
- 2:00 THE POSSIBLE ROLE OF A COMMUNITY HOSPITAL IN POSTGRADUATE TRAINING Frank Glenn, M.D.
(Cornell University Medical College)
- 2:30 TETANUS TOXOID Yale Kneeland, M.D.
(College of Physicians and Surgeons, New York)
- 3:00 THE ACTION AND USE OF THE NEWER DIGITALIS PREPARATIONS Harry Gold, M.D.
(Cornell University Medical School)
- 3:45 BLOOD BANK Sir Lionel E. H. Whithby
(Regius Professor of Physic, Cambridge, England)
- 4:15 THE TREATMENT OF SYPHILIS Joseph E. Moore, M.D.
(School of Medicine, Johns Hopkins University)
- 8:00 (Dinner)
VETERANS ADMINISTRATION ORGANIZATION AND FUTURE PLANS
Major General Paul R. Hawley, MC
(Chief, Medical Division, U. S. Veterans Administration)

continued on page 672

PALATABILITY AND NUTRITION FACTORS *of*



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Q. What is the importance of palatability?

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Q. Why are the different ingredients selected?

A. Campbell's Strained Baby Soups are planned to provide a balance in nutrients to supplement the daily milk diet. Since it takes many different foods to supply the approximately 40 nutrients needed for infant development and energy, we use vegetables and a cereal in preparing each of the four meat soups. Flavor is improved, too. For instance, liver alone has too strong a taste for some babies, but blended with vegetables, palatability

is enhanced. It should also be noted that these soups are intended for use as early in normal infancy as any other strained baby foods.

Q. What measures are taken to conserve food constituents?

A. In preparing these Baby Soups, Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins.

A comprehensive analysis of each soup may be had upon request to Campbell Soup Company, Camden, New Jersey.

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OCTOBER 31—Morning Session

- 9:00 WHAT CAN X-RAY THERAPY DO FOR MALIGNANT CONDITIONS
Eugene Pendergass, M.D.
(*School of Medicine, University of Pennsylvania*)
- 9:30 EARLY RECOGNITION OF CARCINOMA IN THE UTERUS
Lewis C. Scheffey, M.D.
(*Jefferson Hospital, Philadelphia*)
- 10:00 PART II. 200 OBSTETRICAL CONSULTATIONS IN PRIVATE PRACTICE
Nicholson J. Eastman, M.D.
- 10:45 ANTIBIOTICS Yale Kneeland, M.D.
(*College of Physicians and Surgeons, New York*)
- 11:15 GYNECOLOGY IN THE COMMUNITY Lewis C. Scheffey, M.D.
- 11:45 A CRITICAL ANALYSIS OF THROMBOPLEBITIS Irving S. Wright, M.D.
(*Cornell University Medical College*)
- 12:15 (Luncheon. Hotel Bradford)
INFLUENCE OF GOVERNMENT ON MEDICINE IN ENGLAND
Sir Lionel E. H. Whithy

OCTOBER 31—Afternoon Session

- 2:15 THE GENERAL PRACTITIONER LOOKS AT HIS JOB . . . Donald Clark, M.D.
(*Monadnock Community Hospital, Peterborough, N. H.*)
- 2:45 HEPATITIS John Paul, M.D.
(*School of Medicine, Yale University*)
- 3:30 THE DIAGNOSIS AND TREATMENT OF THE NEURO-VASCULAR
SYNDROME OF THE SHOULDER GIRDLE Irving S. Wright, M.D.
- 4:00 TYPES AND TREATMENT OF DEAFNESS Alfred T. Lieberman, M.D.
(*Johns Hopkins Hospital, Baltimore*)



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FROM ONE CARDIAC TO ANOTHER

(The following letter was written to a patient of a Providence physician, and it is published here because of its excellent presentation of a sound philosophical viewpoint for the cardiac patient.)

—THE EDITOR)

Dear Mr.,

I was greatly disappointed when Dr. and Miss M came and you were not with them, and grieved to learn that you had a cardiac mishap and were still in the hands of the medical men. I welcome you into the great company of the cardiac convalescents (What a name!) and am writing this to assure you that you will find living with a damaged heart not nearly as bad as it seems in the first months of the experience.

On the positive side you will have hereafter a perfect alibi for dodging the things you do not want to do, and a complete excuse for the most flagrant laziness. On the other side you will have to make a rather complete change in your way of life; but the new way will not be at all unpleasant.

I find in my own case that I can no longer row a boat, or run long distance races, but there are many things that I can do that are highly entertaining. When I walk slowly, as I must, I have better opportunity to observe what goes on about me. If I must talk less, it is no doubt to the improvement of what I have to say. If I eat less I enjoy what I can have all the more. I can sit and observe that most interesting of all wild animals, *homo sapiens*, and exert all my abilities trying to figure out why he acts as he does. I can take time to think and write for my own amusement and to read the many things that I have had to leave unread in the past. I am seldom bored. I miss coffee, tobacco and strong drink—tobacco most of all—but they are not the best of life.

So, having adjusted my mental attitude to my present physical capacities I do well enough and I am sure that you will be able to do so.

The old farmer in Michigan who said "Life ain't nothing but three things: filling what's empty, emptying what's full, and scratching what itches" was not far wrong. If we take it one day at the time, and do not fail to enjoy what is there to be enjoyed, we can get a lot out of it. We are only recently out of the tree tops, after all, and don't deserve too much.

You will soon be up and about again. Follow the regimen the physicians lay out for you except where it would make life unendurable. Tell your doctor that you want him to manage things so that you can do what you want to do, and not think that he has done his duty when he tells you that you can't do anything that's any fun.

I shall look forward to seeing you next summer, and in the meanwhile shall burn a candle to St. Anthony of Padua with the request that you will soon be able to return to the kind of life you want to lead.

Sincerely yours,



Truly, this is America . . . the mothers go to school

More than 3,000,000 American mothers, members of some 45,000 Parent-Teacher Associations and similar groups, go back to school to keep on learning the art of living.

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In this achievement, American medicine has smoothed the path by keeping its physicians completely free agents—free to speculate in and

develop any of the countless fields encompassed by the art of healing.

Just as American mothers exchange freely their knowledge and methods of their children's problems, so do American physicians exchange their skills and knowledge.

HERE in laboratories located in the typical American community of Summit, New Jersey, medical men of the Ciba organization are spending their lives in pursuit of the newer and finer pharmaceuticals with which the medical profession determinedly advances the treatment of disease. Free to follow their own lines of research, each speeds the work of his associates through open exchange of methods and ideas.



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HOSPITAL CONSTRUCTION ACT

With the signing by the President of the Hospital Survey and Construction Act, an appropriation of 375 million dollars is authorized during the next five years for the construction of hospitals and health centers. Three million dollars is also authorized for State-conducted surveys of need. These must be made preliminary to the granting of Federal funds for construction.

The Act provides latitude for each State to develop its own program of hospital and health center construction, to be administered by State authorities under standards specified by the United States Public Health Service. The Surgeon General will be assisted in establishing standards by a newly created Federal Hospital Council consisting of eight members to be appointed by the Federal Security Administrator.

"This Act sets for the first time a national policy which makes it clear that hospitals in the future must be planned, located and operated in relation to the overall health needs of the people," Thomas Parran, Surgeon General, U. S. Public Health Service said. "This policy, as evolved through the leadership of hospital authorities of the country, is recognition of the integrated role that hospitals and health centers must play in the future. Adequate hospitals, health centers and related physical facilities are the essential workshops, without which it is not possible to provide even a minimum of modern health and medical services."

Any State may initiate action by submitting a request to the Surgeon General for funds to carry out an inventory of existing hospitals, and to prepare a plan for the construction necessary to provide adequate care for all the people. In making the request, the States must designate a single State agency to carry out the survey and planning and must appoint a properly qualified advisory council to consult with the State agency. The proportionate share for each State of the total Federal appropriation for survey and planning will be determined by the populations of the several States. However, Federal funds must be matched by two to one in defraying the survey expenses.

Allotments for the actual construction of facilities will not be made until the State plan based on the survey findings has been approved. Construction allotments to individual States will vary in amount. Population will be one factor, and in addition, the average per capita income will be used in the allotment formula in such a way that States with a lower per capita income, where there is relatively greater need for medical facilities, will receive proportionately larger allotments per capita.

Applications for funds for individual construction projects must be channeled through the designated State agency. Here again, Federal funds may not exceed one-third of the cost of a project. Before any single project is approved by the Surgeon General, sufficient evidence must accompany the building request to show that two-thirds of the total cost of construction is available from other-than-Federal sources, and that financial support is adequate for the maintenance and operation of the institution after completion.

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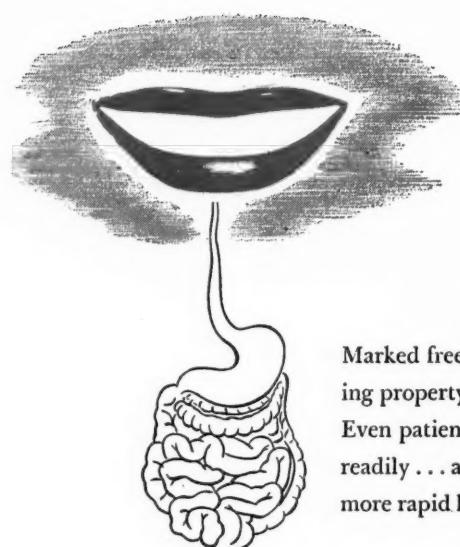
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*Reznikoff, P., and Goebel, W. F.; *J. Clin. Investigation* 16:547, 1937

Trade-Mark *Fergon* Reg. U. S. Pat. Off.

HOSPITAL ASSOCIATION OF RHODE ISLAND

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ARTHUR H. RUGGLES, M.D., Editor

WOONSOCKET HOSPITAL

WOONSOCKET HOSPITAL received its first patient on October 10, 1888. During its first full year of operation, thirty-nine patients were cared for, hardly one third of the number who are now cared for daily. It is interesting to contrast the small beginning with the following figures showing the growth of the hospital in service to the community during the years which ensued:

Fiscal Year	Number of Patients	Average Days' Stay	Average Daily Census	Patient Days for Year
1893	97	41.8	11.2	4,088
1903	150	24.8	10.8	3,944
1913	492	20.	27.0	9,855
1923	1365	10.5	39.2	14,312
1933	1997	9.3	51.05	18,633
1943	4743	8.6	112.0	40,801

Many persons speak of "the good old days when we had gas street-lights and low hospital bills." Ward Care in the old days cost \$10.00 per week. The average stay of a patient here was 42 days in 1893 at a cost of \$60.00. The average days' stay is now about 9 days. At \$5.00 per day (Ward Care) this comes to \$45.00. Considerable saving there. Of course, costs for extra items are higher because Doctors are using many drugs and supplies which are costlier than in the old days. However how much is it worth to be sick for a few days compared with many days. How much can the bread-winner earn in the days saved from his former sick time. How much is it worth to an employer to have his experienced workman back on the job. How much is it worth to the family to have their sick person back with them quicker and with far more chance for becoming well and useful again. And how much is it worth to have the fine surroundings and well-trained personnel which makes for modern hospital care.

To get back again to Woonsocket Hospital in particular, the buildings are a combination of the old cottage type frame construction hospital and a more modern V-shaped brick building. Previous generations were quite proud of cottage type hos-

pitals. It was believed, probably correctly, that individual care would be more personal in that type hospital as compared to care in the institutional type. With the great increase in number of patients it would have been unwieldy and very costly to have continued the old system. Evidently those responsible liked the cottage type so — when the more modern building was erected it was located in the background. Many persons wonder why the initial view of the entire Woonsocket Hospital brings the cottage type buildings into such prominence.

The buildings are located in the center of the Cass Avenue front. There are 24 acres of land. The property has frontage on three streets. The grounds have many shade trees although the hurricane of 1938 destroyed nearly 150 of these of various kinds. During recent years lawns, shrubbery and trees have been added.

The hospital is rated as a 184 bed institution and is approved by the American College of Surgeons, the American Medical Association and the American Hospital Association. Some of the departments, the Maternity Department in particular, are running considerably above normal. At the present rate the Maternity Department will rank second to the Providence Lying-in Hospital in this state for number of babies born annually. While only a few prospective mothers came for confinement to the hospital prior to 1935 the hospital has recently given a celebration for its 10,000th baby.

The various hospitals outside the Providence—Pawtucket area are doing a splendid job not only in rendering hospital care in the patients' own community but in relieving what would be a tremendous pressure on Providence—Pawtucket hospital facilities. Few persons consider this side of the hospital picture. The hospital load outside the Providence area equals approximately 50% of the Providence area load. Massachusetts and Connecticut residents are cared for in these hospitals to a considerable number.

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exceptional cases (such as prematures and others requiring larger amounts of vitamins in their diet) the vitamin D content has been raised 300 U.S.P. units.

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MEDICAL LIBRARY NEWS

THE LIBRARIAN of the Rhode Island Medical Society Library announces the recent addition of the following books:

BIOGRAPHY

T. G. Wilson—*Victorian Doctor. Being the Life of Sir William Wilde.* N. Y., 1946.

DIGESTIVE SYSTEM

S. Wolf & G. Wolff—*Human Gastric Function.* N. Y., 1943.

GERIATRICS

E. J. Stieglitz, editor—*Geriatric Medicine.* Phil., 1943.

INFANTILE PARALYSIS

R. H. Berg—*The Challenge of Polio.* N. Y., 1946.

A Bibliography of Infantile Paralysis, 1789-1944. Phil., 1946.

MALADJUSTMENT

L. E. Hewitt & R. L. Jenkins—*Fundamental Patterns of Maladjustment.* 1946.

MEDICINE

F. K. Albrecht—*Modern Management in Clinical Medicine.* Balt., 1946.

J. C. Meakins—*The Practice of Medicine.* 4th ed. St. L., 1944.

H. Rypins—*Medical Licensure Examinations.* Phil., 1945.

METASTASES

M. W. Thewlis—*Metastases.* Charlotte, 1944.

NEUROLOGY AND PSYCHIATRY

F. A. Mettler—*Neuroanatomy.* St. L., 1942.

E. A. Spiegel, editor—*Progress in Neurology and Psychiatry.* N. Y., 1946.

PROCTOLOGY

M. G. Spiesman—*Essentials of Clinical Proctology.* N. Y., 1946.

RESUSCITATION

P. J. Flagg—*The Art of Resuscitation.* N. Y., 1944.

THERAPEUTICS

Transactions of the American Therapeutic Society, 1943-1944.

WAR MEDICINE

The Effect of Bombing on Health and Medical Care in Germany. Wash., 1945.

The Library has received gifts of pamphlets, unbound journals and bound volumes from Doctors Clara and Joseph Smith, the Providence Public Library, Ethicon Suture Laboratories, Eli Lilly Company and Nutrition Research Laboratories.

BOOK REVIEW

IT'S HOW YOU TAKE IT, By G. Colket Caner published by Coward-McCann).

"It's How You Take It" is a concise, helpful, good sense book on "meeting life." The book is simply and clearly written in non-technical language. It fulfills the reader's need to know more about himself.

The author's aim was to produce a book that could be read with interest and profit by late teenagers, but his book should be equally helpful and interesting to adults, particularly to parents and teachers, and to physicians who want a book that they can give to nervously upset patients with confidence that it will not be upsetting and will be helpful. The author is a practicing neurologist and psychiatrist, but the book is one that a well person as well as a nervously upset person can read with profit. It would be an excellent book for a physician's waiting-room, quite like Dr. Walton's "Why Worry," and "Those Nerves," of two decades ago.

CHARLES A. McDONALD, M.D.

LIBRARY NIGHT HOURS

Starting September 17 the Medical Library will be open every TUESDAY, WEDNESDAY, and THURSDAY EVENING from 7 until 10 p. m., except when a holiday falls on one of these days. The continuance of this service for the benefit of members unable to visit the Library during the day hours will depend upon the use made of the facilities during the next three months.

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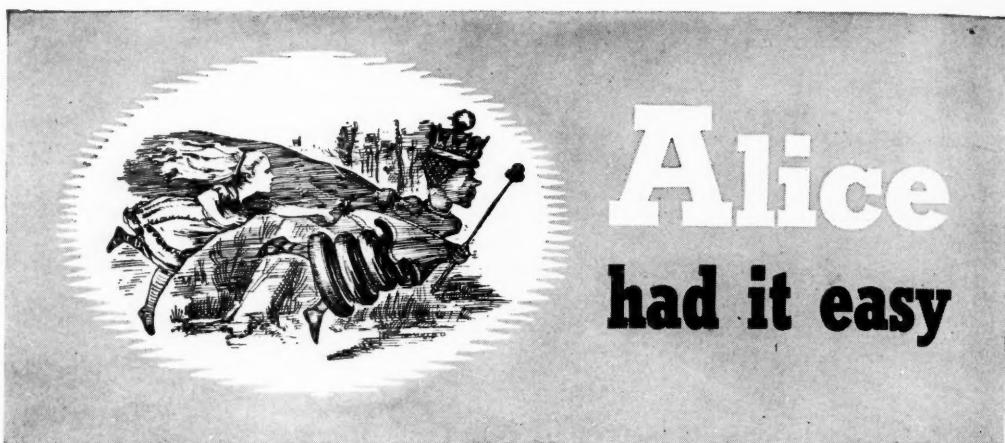
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THE EXPANDED FEDERAL-STATE VOCATIONAL REHABILITATION PROGRAM*

CHARLES L. NEWBERRY, M.D.

The Author. *Charles L. Newberry, M.D., of Washington, D. C. Senior Surgeon (R) U.S.P.H.S.; Assistant Medical Officer, Office of Vocational Rehabilitation, Federal Security Agency.*

IT is remarkable that nearly a quarter-century of organized effort had been devoted by the Federal-State program, to the rehabilitation of the vocationally handicapped, before Federal funds became available to the States for the institution of "physical restoration" services. Less than three years have elapsed since it was recognized that the most important determination in the case of a sick or disabled individual is the answer to the question: "Need this man *keep his defect?*"

As co-workers in the field of health we can rejoice in this recognition of the fact that medicine can often do more than palliate and counsel patience; that medicine can quite often remove a handicap, and still more often, can so reduce it as to put a brighter face upon a drab life.

The Medical Social Workers of Rhode Island were kind enough to sponsor my visit here, and I hope that they will not object to my remarks as too much medical, and too little social. I feel, however, that all of us in the healing field are going to do our best work if we consider all of our jobs as extensions of the central arm of all medical services, powered by all members of the healing professions acting as a unit, and expending their co-ordinated energy upon the whole individual, instead of upon his constituent parts.

The physically and mentally handicapped are or have been sick people. Most of them are or have been the patients of physicians. All of them should have the advantage of whatever the healing art can do for them. Many of them still need a fair amount of medical treatment.

Until 1943, this treatment was rarely given as a rehabilitation service. An elaborate system of training and selective placement had to be built around a defect. At best, we ignored curable defects; at worst, the defect, and not the cure was the important thing.

*Presented at the Annual Meeting of the Rhode Island Medical Social Workers, at Providence, May 15, 1946.

To re-establish medicine as a vital force in rehabilitation calls not only for a different and more constructive type of thinking, but demands a vast amount of medical advice and guidance. We must no longer tenderly nourish curable defects. We must, instead, unremittingly seek their elimination.

Thus, we shall need more than your passive approval and tacit support; we should like to invite you to take a dynamic part in a most fascinating and profitable program. I say profitable advisedly, since it has been our experience that money spent on physical restoration and the other rehabilitation services is repaid many fold, not only in satisfaction and self-respect, but in a measurable cash return, not only to the individual helped, but to the governmental source of that help.

In addition to our medical needs, we are finding that many of the problems in rehabilitation lie in the field of social adjustment and human relationships. We need help in exploring the ways in which the physician, the medical social worker, the psychiatric social worker and the public health nurse, to name only a few, can be brought to bear upon the needs of the client, his family and his social environment.

We do not make medical treatment available for reasons of sympathy. Our civilian program lacks the emotional and patriotic appeal engendered by the gratitude and obligation of a nation to its disabled veterans of the armed forces. Our work has specific objectives, and specific limitations. We cannot become involved in medical care, except insofar as it is related to an employment handicap and a job objective.

It is our special job, whenever practicable, to get the disabled out of bed and out of wheel chairs, and fitted to earn a living. Less we cannot do; more, we may not and should not do as a rehabilitation agency. We do not forget the humanities; our wish to remember them finds ample fulfillment in opening our clients' eyes and minds to a new world full of new opportunities.

We bend every effort toward helping the client forget the leg, the strong back, or the eyes that he can no longer use. Instead, we try, where we cannot cure a handicap, to stimulate toward produc-

continued on next page

tive employment usefulness, the keen mental eyes of the blind, and the untapped physical and mental resources of the crippled. There are some resources which no misfortune can completely tear out of a life. We try to help find and use them.

I should like to invite your attention to the phases of the various services attempted under our program.

I. REHABILITATION SERVICES PROVIDED

A. Physical Restoration: This includes whatever is done on the medical side, and is placed first, since one of the first steps is a general medical appraisal and diagnostic examination.

B. Testing: Intelligence and aptitude tests to determine mental ability and capacity to absorb training. These tests eliminate most of the on-the-job breakdowns.

C. Guidance and Counseling: The skilful counselor is worth his weight in gold. He must know something about the 32,000 different jobs at which men work. He must know, or find out enough to keep the arrested TB patient, for example, out of silica dust.

Through his hands pass the application, the medical reports, the initial authorization for treatment, training, tools, equipment, and so forth.

His work caps the climax of physical cure, and with the addition of medical and psychiatric social work, even adds the finishing touches to the picture of complete physical, mental and emotional adjustment to the new life. He needs your constant guidance as physicians and medical social workers. In many of your own cases, he can provide the missing non-medical means of restoring your handicapped patient to productive employment. You will find him a valuable extension of your own services.

D. Training: Practically any training for which the individual is fitted by his mental capacity and his aptitudes, may be given. Even a limited, but adequate number of tools of his trade can be furnished, if he is truly indigent. An expensive artificial arm and hand are wasted without training in their use, and training of the remaining normal limb. This *training* is one reason why properly rehabilitated handicapped employees have fewer accidents, work more steadily, have less absenteeism, and equal or exceed their "well" fellow-men on the job. These are employer and insurance company statements.

E. Placement: A science in itself. Employers have recognized the fact that, except for a comparatively few individuals kept in civilian life during the recent war because they were classed as essential, the recent most productive industrial period in our history was kept up, as one writer puts it, "by women, old men and 4F's!" The counselor helps the client to select one of the 32,000 kinds of jobs, then sees that he is specifically trained for it.

F. Follow-up: That explains itself. Occasionally, especially for the severely handicapped, some smoothing-out of employment conditions is needed, in shops that never before employed "handicapped" workers.

Except in the learned professions, there are few persons seeking employment, who are so specially fitted and selectively placed in the particular job for which they have been specially trained, as the average rehabilitation client. This is another reason for his popularity with employers and insurance companies. Many of them go out of their way to publicize their desire for handicapped employees!

II. PHYSICAL RESTORATION SERVICES:

A. Physical Examination and Diagnosis: We use a form — it must be a fairly satisfactory one, because half of the doctors call it too long and detailed, and half think it should be longer!

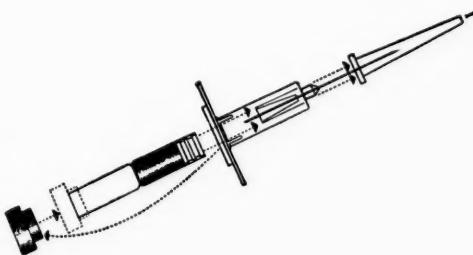
It is not just a form; it is a chart which the counselor and the client will refer to in planning each further step in the process. We do ask, therefore, that it be complete to the last detail. Our answer to the criticism that we ask too much information from the doctor, is that we believe in medical guidance. Since our procedures are made to conform to your prescription, we must be sure that the prescription is not only complete, but that we understand exactly what you do and do not want done.

An example: In a recent survey among blind persons, it was found (where there was any medical record at all), that the most recent physical examinations were nine years old, and that when made, that examination disclosed physical defects in only 1% of blind persons. Why? Because interest in the blindness had resulted in inadequate attention to the "whole man", for obviously, blind people are also susceptible to other defects. Some of these defects might render them completely ineligible for any of our services.

continued on page 688



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VOCATIONAL REHABILITATION PROGRAM

continued from page 686

Other defects must be known to us, or the expensive counselling, training and guidance will be wasted, and we will be criticized for missing an early tuberculosis; an advanced, metastatic carcinoma.

The examiner is — we hope — the family doctor. His positive statement determines the existence of a substantial handicap; and determines whether a reasonable amount of treatment would be a measurable aid in making the client competitively employable.

B. *Review by Medical Consultant:* This man is also a local doctor. He explains the meaning of the terms and conclusions reached to the lay members of the staff, and trains the staff to a recognition of the basic health demands and health risks of industry. He stands by the counselor to assist him in seeing that the medical prescription and the job diagnosis and placement go hand in hand. He discusses with the physician and the counselor the meaning of the term "static" as applied to a medical condition. He answers such questions as: "Is amputation for osteosarcoma a proper rehabilitation undertaking?" "What about pneumothorax service in arrested TB?" "What can be done to make the diabetic more employable? The epileptic? The psychoneurotic? The cerebral spastic?" This work costs money. However, Clark D. Bridges, Director of Conservation Services of the Zurich Insurance Companies, mentioned in his excellent book "Job Placement of the Physically Handicapped", that one survey has resulted in a report that for every dollar spent on rehabilitation, \$47 was returned to society.

C. *Hospital and Nursing Care:* Including physical and occupational therapy.

D. *Corrective Surgery:* Some cases receive non-surgical treatment as well.

E. *Dental Care:* This is restricted to conditions wherein the dental defect is in itself a substantial employment handicap, or where, in competent medical opinion, it is a necessary part of the treatment of an existing major physical handicap.

F. *Prosthetic Appliances:* This has become a highly specialized field. It has been estimated that as many as 50% of those purchasing artificial limbs do not wear them.

The patient who removes his dentures and eats corn-on-the-cob with his gums; the woman who spent \$1000 for a pair of artifi-

cial legs and fell flat on her face when she tried to wear them, and thereafter returned to her wheel chair; the girl of 16 who went through school without a limb to fit her thigh-amputation stump, only because someone once told her parents that children should not have artificial limbs fitted until they had "gotten their growth" (!); the man who had a technically perfect Pirogoff amputation, only to learn that no artificial limbs had been made to fit such a stump for 25 years — all these are examples of how not to do things.

It is essential to get the surgeon, the limb manufacturer, the client and the counselor together at the earliest possible moment, preferably before the amputation. The prosthesis must fit not only the patient, but his job requirements. Publicity of the wrong kind has convinced many amputees that they can buy an artificial limb that will do everything a flesh-and-blood limb can do. Such pioneers in the field of cineplastic amputations as Dr. Henry Kessler, emphasize most trenchantly and dramatically their limitations, and plead for a realistic, "demands-of-daily-living" kind of limb.

* * * *

It costs from \$200 to \$500 a year to keep a handicapped man on the welfare rolls. . . . It costs less than \$300 to make him self-supporting at an average wage of \$1700 a year, via the doctor, the training, the counselor and the placement route.

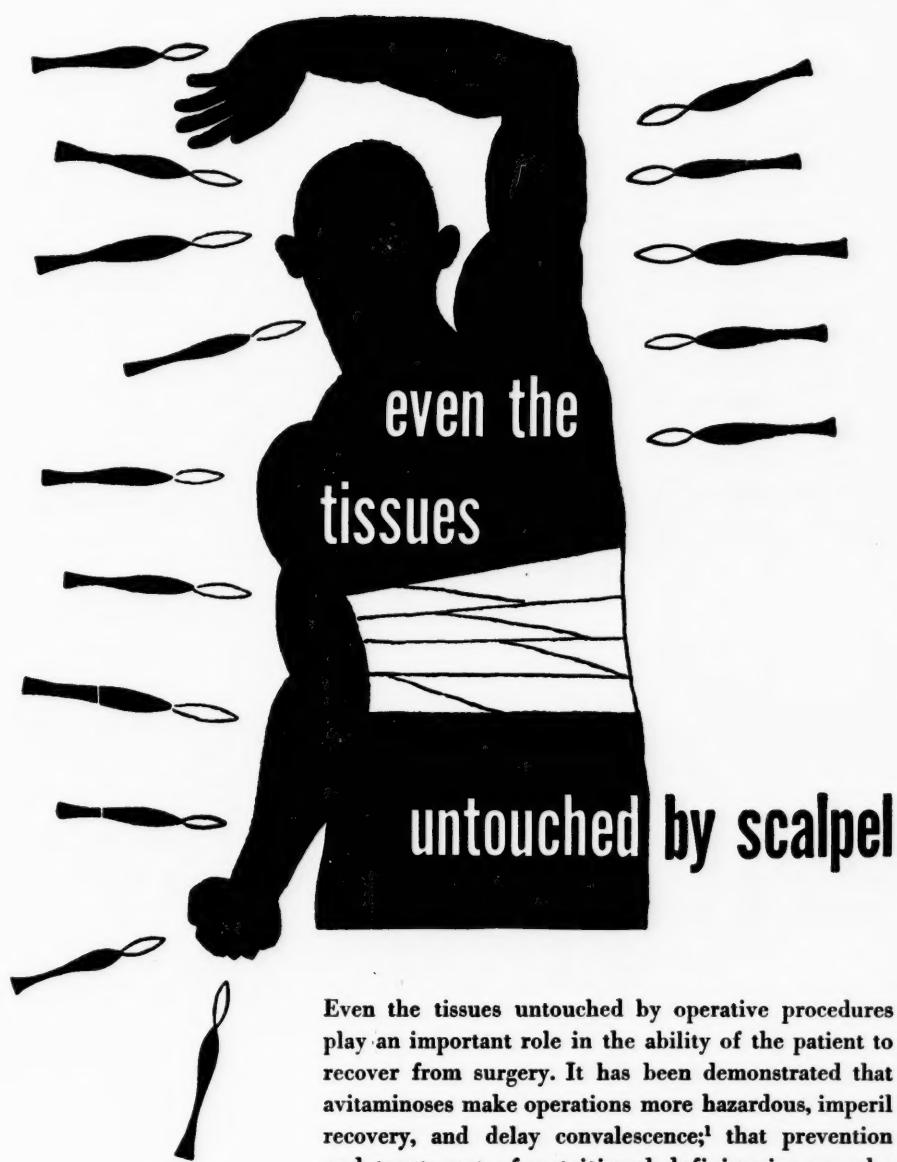
Perhaps 2,000,000 people have severe handicaps. Undoubtedly many more could be added, whose handicaps are concealed by reason of pride. A half-million Americans are classed as major amputees, requiring artificial limbs. About 40,000 new major amputees join the ranks of the crippled every year. Even during the recent war, civilian major amputees outnumbered the military cases, 3 to 1.

Rehabilitation in the TB Sanatorium

Of our 600,000 cases of active tuberculosis, many should some day support themselves. In sanatoria which have introduced rehabilitation services, the number of those leaving the "san" without medical permission has been cut 90%! Four out of five who so leave, were formerly reported dead within five years. Rehabilitation, started as soon as medically permissible, encourages the will to get well. The saving of lives is dramatic.

Equally brilliant is the effect upon the future health of those who complete their stay in the

continued on page 691



Even the tissues untouched by operative procedures play an important role in the ability of the patient to recover from surgery. It has been demonstrated that avitaminoses make operations more hazardous, imperil recovery, and delay convalescence;¹ that prevention and treatment of nutritional deficiencies may be "decisive"² in recovery following surgery. In the field of oral and parenteral vitamins, Upjohn offers a full range of highly potent, convenient to administer, economical vitamins.

1. Virginia M. Monthly, 72:240 (June) 1945.
2. Am. J. Surg., 54:299 (April) 1942.

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1. Ragan, C., and Boots, R. H.: New York Med. 2:21, 1946.

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VOCATIONAL REHABILITATION PROGRAM
concluded from page 688

"san" and are dismissed as "arrested". Of those who are dismissed without having had rehabilitation services, six times as many break down and return with reactivated tuberculosis. Counseling, training and selective placement in "safe" employment has proved to pay rich dividends in time, health, public safety and public money. I dislike to paint too glowing a picture of success in dealing with a disease as subtle as tuberculosis, so I suggest only that if you wish to find an amazing and inspiring conclusion, calculate from these figures rehabilitation's saving in lives of the tuberculous in terms of 100 active cases, or of 100 sanatorium admissions!

In paying the costs of medical services, we must remember that since these clients are required to demonstrate inability to pay for their care, the ordinary test of a fee based upon a reasonable ability to pay does not apply. There are no "charity" cases, for which you receive nothing. There are no well-to-do patients to carry your overhead and to compensate you in part for your "free" cases.

The fees agreed upon between the State Rehabilitation Agencies and the State Medical Societies are, in my own experience, always at about the level of average charges to patients of moderate means. They are not "welfare" rates, and are set up in accordance with the principle that a good medical diagnosis and thorough medical treatment are well worth their cost.

In closing, I want to urge the medical and economic soundness of getting more cases *from* doctors as clients, as well as getting more cases *to* doctors as patients. The closer the timing between medical services and rehabilitation, the cheaper, the better and the more satisfying is the end result. We doctors and medical social workers can now get our patients back on their feet without the years of discouragement that come to the jobless object of charity.

Most of the medical guidance of this program comes from the practicing doctors in the patient's own community and State. Medicine is just coming into its own in rehabilitation. The program has some "bugs", as does any new undertaking. The closer we can bring the family physician to the rehabilitation counselor, the fewer will be the complaints, the difficulties and the failures.

My message to the Rhode Island Medical Social Workers and to the State Medical Society itself, is a plea for more medical guidance from those best qualified to give it — those to whose care the welfare of the lame, the halt and the blind has been committed since the beginnings of civilization — the practitioners of the healing art.

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SEP
DISTRIBUTION OF STREPTOMYCIN

Limited commercial distribution of streptomycin through designated hospitals for treatment of civilian patients will begin September 1, the Civilian Production Administration announced recently.

The plan, which is similar to that used initially for penicillin distribution, was authorized by amending Schedule 119 to Order M-300.

CPA officials said that more than 1,600 general hospitals have been selected as depots for the drug and will supply other hospitals in their respective areas. They were selected with the assistance of an advisory panel including Dr. Chester S. Keefer, National Research Council; Dr. C. J. Van Slyke, U. S. Public Health Service; and Dr. Victor Johnson, American Medical Association. Pending their notification, the names of the depot hospitals were not released by the Chemicals Division.

Until now the small amount of streptomycin available has been distributed by CPA to meet the urgent needs of the Army, Navy, Public Health Service, Veterans Administration, and also to the National Research Council to carry on as integrated clinical research program to determine the conditions amenable to streptomycin treatment. Streptomycin producers have contributed nearly \$1,000,000 to finance the program carried on by the Council's Committee on Chemotherapeutic and Other Agents under the chairmanship of Dr. Chester S. Keefer.

Until September 1, civilian appeals for this drug will continue to be met only from the supply available under the clinical research program. Appeals should be made by the physician in charge of the case to Dr. Keefer, Evans Memorial Hospital, 65 East Newton Street, Boston, Mass.

Beginning September 1, physicians should contact their local hospitals to obtain the drug. CPA's Chemicals Division shortly will give civilian hospitals full information about the distribution plan, the names of depot hospitals and copies of Dr. Keefer's report on the indications, contraindications, mode of administration, dosage and toxic effects of streptomycin. Depot hospitals will be notified of their September allotments of the drug and told who their suppliers will be.

Chemicals Division officials emphasized that the distribution plan provides that depot hospitals place their orders direct with the designated suppliers, an important difference from the plan used in the initial distribution of penicillin by the War Production Board.

So that the sharply limited supply of streptomycin will be of most use to the greatest number of patients, CPA recommends Dr. Keefer's report as a guide for use of the drug.

The Keefer report summarizes 1,500 cases reported by physicians from all parts of the United States. It particularly recommends use of the drug for treatment of tularemia, hemophilus influenzae infections, bacteremia due to gram negative organisms, urinary tract infections, and meningitis due to certain specific organisms. Streptomycin has been found to be of questionable value in typhoid fever, brucellosis and salmonella infections and to be ineffective in clostridia infections, malaria, rickettsial infections, virus infections and infections with mold and fungi.

The report includes tuberculosis among a number of diseases for which the drug is a helpful agent but states that in the treatment of these its status has not been definitely defined. It emphasizes that streptomycin will not replace any of the established forms of treatment and that it should not be used as a substitute for other forms of therapy.

Because of the large quantity of streptomycin (a minimum of 135 to 270 grams) needed to treat tuberculosis, the present supply will not be sufficient for general use against

continued on page 697

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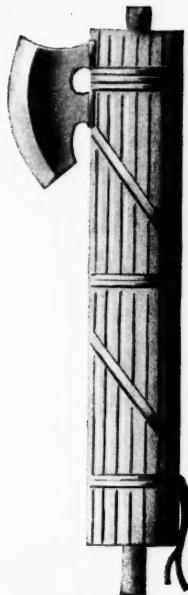
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THE WASHINGTON SCENE

ALTHOUGH Congress recessed last month without taking final action on several proposed measures involving controversial issues in the field of health and medical legislation, it should be carefully noted that these measures are not dead, but are merely dormant. There is a persistent rumor in the nation's capital, confirmed by a statement from the Senate floor on August 2, that the President will call an extra session of Congress for the express purpose of trying to push through social legislation that has been by-passed. The answer lies in part in the fact that if the House should go Republican in the November elections the President would face a trying two year period prior to the presidential campaign, and it might be impossible for him to get favorable action on some of the remaining portions of his legislative program. Anything can happen from now until the end of the year with clever legislative strategy being employed with respect to the Wagner act and the Pepper bill.

Some of the significant actions taken as the 79th Congress wound up its affair prior to the recess may be summarized as follows:

HILL-BURTON BILL. This measure to provide for the expansion of hospital facilities in the States had the approval of the American Medical Association, and the various hospital groups. The Senate Education and Labor Committee worked on the bill for two months in executive sessions and gave much thought to the formula for the distribution of funds. It devised one that would aid the poor States to obtain health centers and hospitals sorely needed. However, the House changed the formula when it received the bill, reducing the Federal matching grant to 33½ per cent, thus militating against some of the very sections of the country that probably should be aided most. Referred back to the Senate the formula was set at 40 per cent by a compromise amendment. The law thus will still give the wealthy jurisdictions a chance to obtain federal grants while impoverished communities will be unable to participate in many instances.

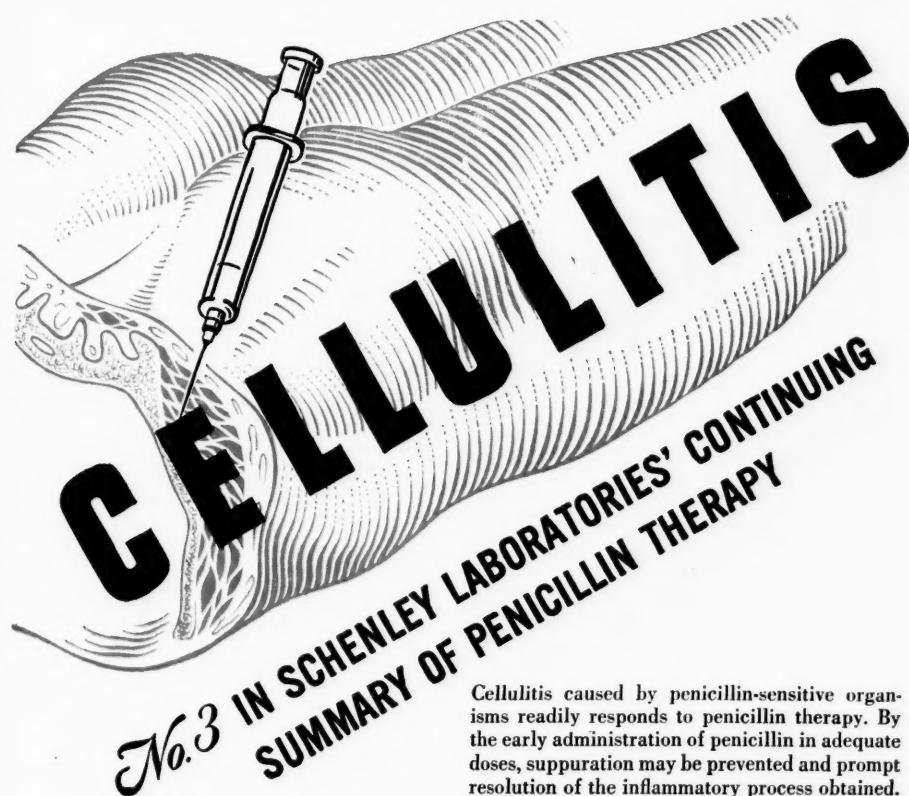
MATERNAL AND CHILD WELFARE. The much-discussed and much-debated Pepper bill which drew strong opposition was not approved by the Committee on Education and Labor, and as a compromise a joint resolution was introduced amending title V of the Social Security Act to provide for increased grants to States for maternal

and child-health services, services for crippled children, and child welfare services. This resolution went to the Senate finance committee which slashed the proposed raise in funds to \$30 million to \$23 million. Even at that the increase about doubled the Children's Bureau grants and for the moment that Bureau has more money but no more power. It is safe to predict that there will be a renewal of the campaign for the original Pepper bill provisions, especially now that the Children's Bureau has been transferred to the already powerful Social Security Board with an additional \$425,000 for administration.

MENTAL HEALTH AND MENTAL HYGIENE. The mental health bill which had the support of medical groups was enacted, but despite strong support for a mental hygiene program to be developed by the Public Health Service, and despite the fact that the Senate approved funds therefor on August 1, House and Senate conferees omitted the entire appropriation from the 1947 appropriation bill the following day. It is reported that conferees thought the USPHS already had adequate funds under existing law to make a start on the program.

CANCER RESEARCH. Several reasons have been advanced for the defeat of the measures proposing programs and appropriations for cancer research. Probably the most reasonable ones are that the bills were too loosely drawn, the requests for federal support were not substantiated by prepared exhibits demonstrating need, and the fact that public and private groups failed to agree on the planning. The emotional appeal of this type of legislation was very evidently outweighed by the lack of clear statement showing why up to \$100 million are needed, where research laboratories would be built, and at what cost, etc.

NATIONAL HEALTH INSURANCE. Hearings on the Wagner Act were discontinued in July, but the printed reports of the hearings, top heavy with those of proponents for compulsory federal control, will undoubtedly be used to good advantage by those seeking to win public support for this type of legislation during the coming months. The national high school debate question for the coming academic year will be on the question of national health insurance, and it is safe to predict that the Wagner hearings will be widely quoted.



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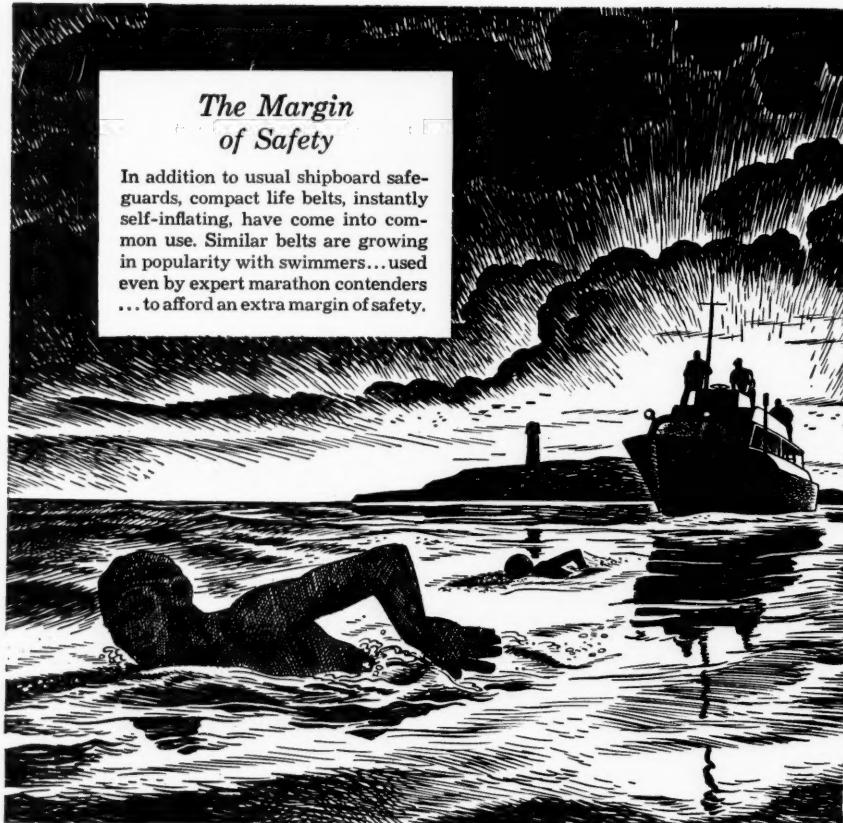
Cellulitis caused by penicillin-sensitive organisms readily responds to penicillin therapy. By the early administration of penicillin in adequate doses, suppuration may be prevented and prompt resolution of the inflammatory process obtained. When abscess formation has occurred, penicillin will localize and control the infection but surgical evacuation of the purulent material may be required to effect a cure.

The administration of penicillin combined, when indicated, with surgical, supportive, and other measures, will in most instances rapidly control and eradicate the infection. Thus, the duration of the disease is shortened, and the possibility of complications reduced to a minimum.

A daily total of 160,000 to 480,000 units, depending upon the severity of the infection, in divided doses every 2 to 3 hours by the intramuscular route will usually be adequate to effect a cure. Duration of the course will depend upon response to therapy. If thought desirable, as a supplement to parenteral administration, penicillin may be employed by local injection or instillation of solutions containing 5,000 to 50,000 units per cc.

WOLLGAST, C. F.: The Clinical Use of Penicillin; A Report of 115 Cases Treated in an Army Hospital, Texas State J. M. 40:225 (Aug.) 1944. FARQUHARSON R. F., GREEY, P., & TOWNSEND, S. R.: Results of Penicillin Therapy: A Report for the Joint Services Penicillin Committee, Canad. M. A. J. 53:1 (July) 1945.

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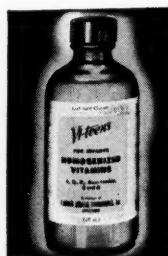


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Niacinamide	4 Milligrams

LANTEEN MEDICAL LABORATORIES, Inc. CHICAGO 10



**DIETHYSTILBESTROL IN THE PREVENTION
OF ORCHITIS FOLLOWING MUMPS**

concluded from page 662

TABLE III
"Hospital Orchitis"

Untreated	Treated with Diethylstilbestrol
16.9%	3.9%

Conclusions

Seventy-seven patients with mumps were treated with diethylstilbestrol. Three of them developed orchitis after treatment was started. One hundred sixty-eight patients did not receive diethylstilbestrol. Twenty-eight of these patients developed orchitis. This form of therapy reduced the incidence of hospital orchitis from 16.6 per cent to 3.9 per cent. Diethylstilbestrol was not found to be toxic in the dose employed.

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concluded from page 692

this disease. The average allotment to a depot hospital for all purposes would treat only one tuberculosis patient. In recognition of this fact the committee warns that no patient with tuberculosis should be started on streptomycin without assurance that an adequate quantity will be obtainable.

CPA said that the great quantity of the drug required for tuberculosis study had made it impossible to supply the amount needed adequately to evaluate the role of streptomycin in treatment of the disease.

However, CPA proposes to make available from the increased supply a considerable quantity for continuing clinical research on tuberculosis. Plans for coordinated research under a suitable sponsoring organization are now being considered.

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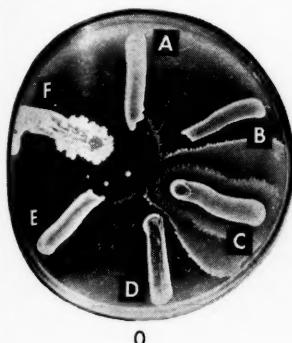
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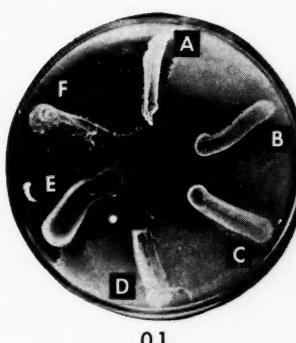
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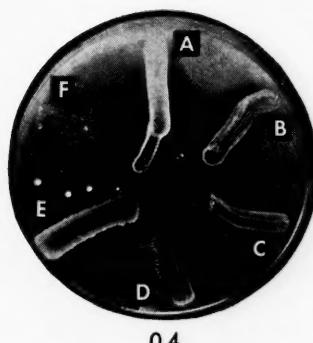
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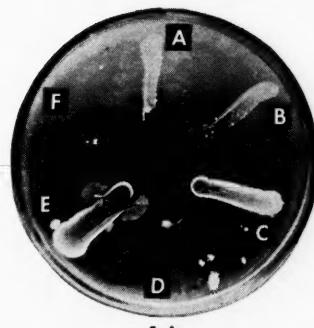
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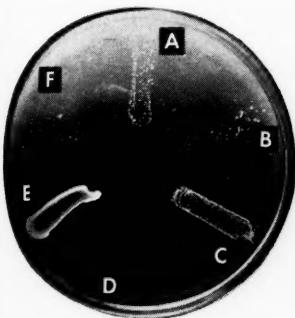
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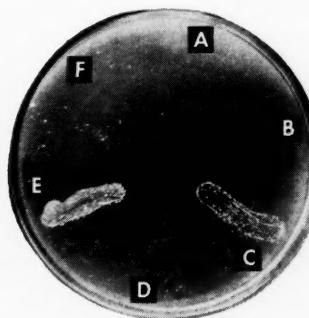
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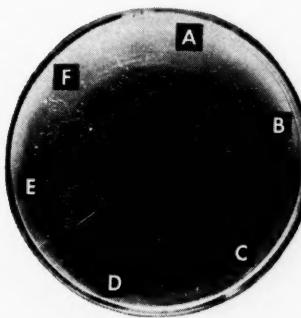
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6.4



26.



104.

THESE photographs show the inhibitory action of increasing concentrations of Streptomycin on a strain of six representative organisms *in vitro*. Inhibitory levels of concentration vary significantly with different strains.

Streptomycin exhibits a wide range of antibacterial activity *in vitro* and *in vivo* against both gram-positive and gram-negative organisms. Clinical results do not necessarily parallel *in vitro* activity or therapeutic results in experimental animals.

In clinical practice, Streptomycin is especially interesting because of its effectiveness against susceptible gram-negative organisms. The most noteworthy results to date have been obtained in the infections listed at the right.

Our production of Streptomycin is being rapidly expanded. However, due to the present shortage, Streptomycin was placed on allocation by the Civilian Production Administration effective March 1, 1946. At present, civilian distribution may be authorized only by Dr. Chester Keefer, Evans Memorial Hospital, Boston, Mass., Chairman of the Committee on Chemotherapeutic and Other Agents of the National Research Council.

URINARY TRACT INFECTIONS
due to
susceptible gram-negative organisms

TULAREMIA

MENINGITIS
due to *Hemophilus influenzae*

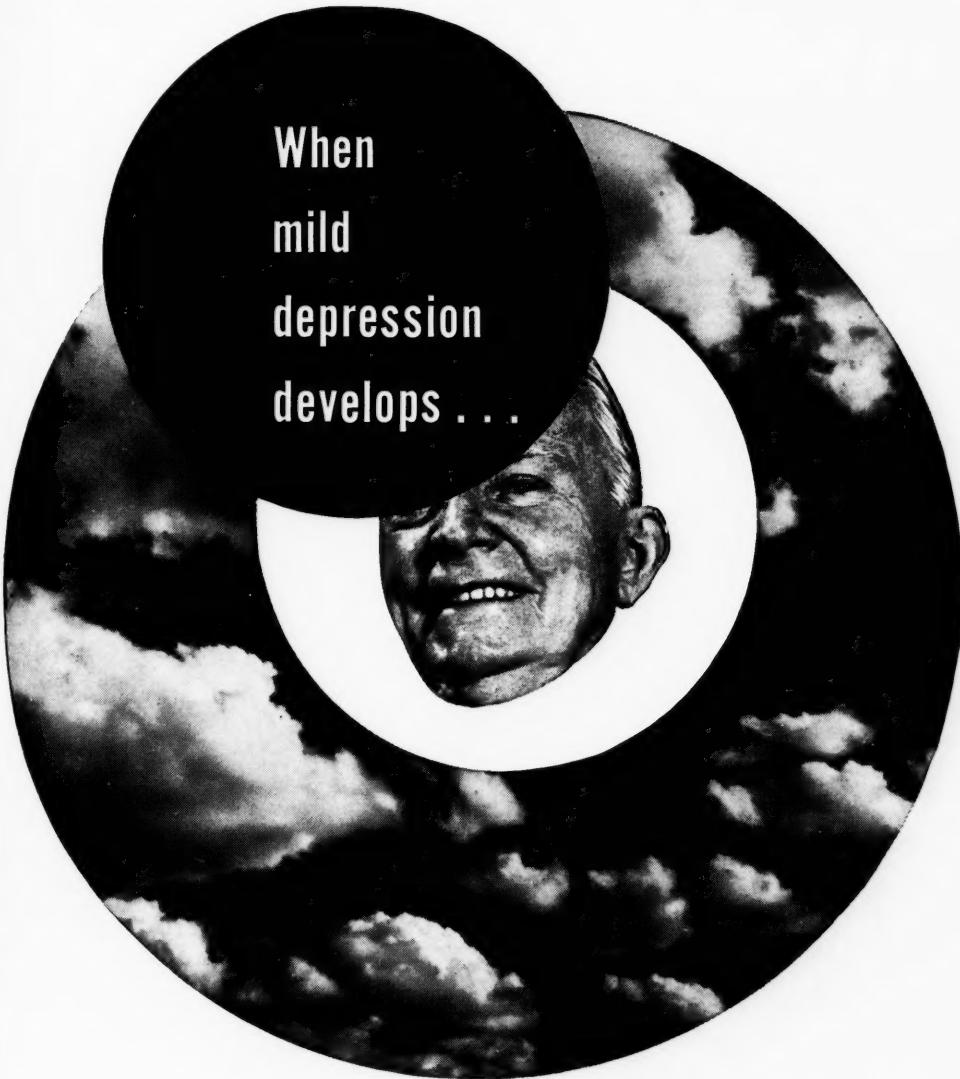
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due to
susceptible gram-negative organisms

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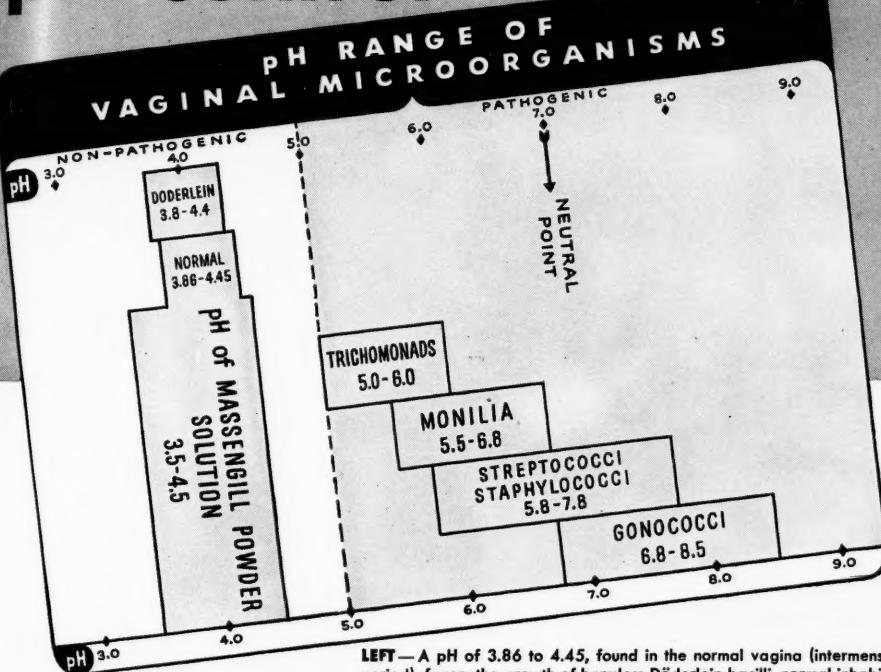
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pH Control



LEFT—A pH of 3.86 to 4.45, found in the normal vagina (intermenstrual period), favors the growth of harmless Döderlein bacilli, normal inhabitants of the vaginal tract. Massengill Powder solution presents a pH of 3.5 to 4.5.

RIGHT—The pH range, 5.0 to 9.0, most favorable to the development of pathogenic organisms.

SINCE the average woman wants and needs advice regarding a proper douche, her physician is confronted by the problem of choosing an effective preparation which is safe, noncaustic and nonirritating. Massengill Powder may be recommended with assurance because it combines therapeutic efficacy, preventive action and hygienic value, with virtual freedom from irritant properties. Its particular advantage lies in control of vaginal pH.

The normal vagina is protected against the

influence of pathogenic organisms by a pH incompatible with their growth. Hence restoration of a normal pH presents the simplest, most direct form of vaginal therapy. Massengill Powder, by providing the desired pH, represents a powerful antibacterial weapon.

Due to its effect upon vaginal pH and to its cleansing action, Massengill Powder solution is equally suitable for regular use in personal hygiene and in the therapy of a wide range of vaginal affections.



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continued on page 706

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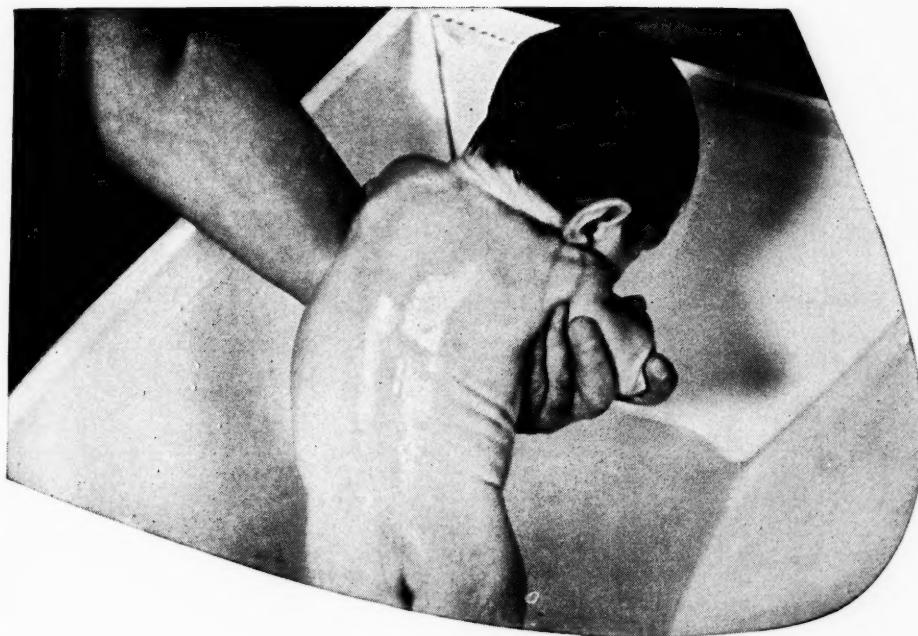


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Newport County Medical Society	James C. Callahan Samuel Adelson	Norman M. MacLeod	President, A. M. Tartaglino Vice Pres., Wm. A. Stoops 2nd Vice Pres., P. P. Ciaria Secretary, H. W. Brownell Treasurer, N. U. Zielinski Censors: N. M. MacLeod John A. Young	4th Tuesday of every other month—Jan., Mar., May, July, Sept., Nov.—usually no July meeting held	January
Pawtucket Medical Association	Earl J. Mara Robert Henry Charles L. Farrell Henry Hanley	James L. Wheaton Earl F. Kelly (alternate)	President, Wm. N. Kalcoures Vice Pres., Earl J. Mara Treasurer, L. A. Sensemeyer Secretary, K. W. Hennessey	On or after 3rd Thurs. of each month at time and place designated by the Pres. (except July-August)	March
Washington County Medical Society	Linwood H. Johnson Julian R. Tatum	John P. Jones	President, S. P. Turco Vice Pres., Louis Morrone 2nd Vice Pres., S. A. Capaldo Sec'y-Treas., J. R. Tatum	January, April, July, October — on second Wednesday of the month	January
Woonsocket Medical Society	H. Lorenzo Emidy Francis King	James McCarthy Saul Wittes (alternate)	President, Joseph Reilly Vice Pres., Richard Dowling Secretary, Alfred King Treasurer, Paul Boucher Censors: E. L. Tremblay George Crepeau Joseph McKenna	2nd Tuesday, alternate months, Sept.-June	Elective
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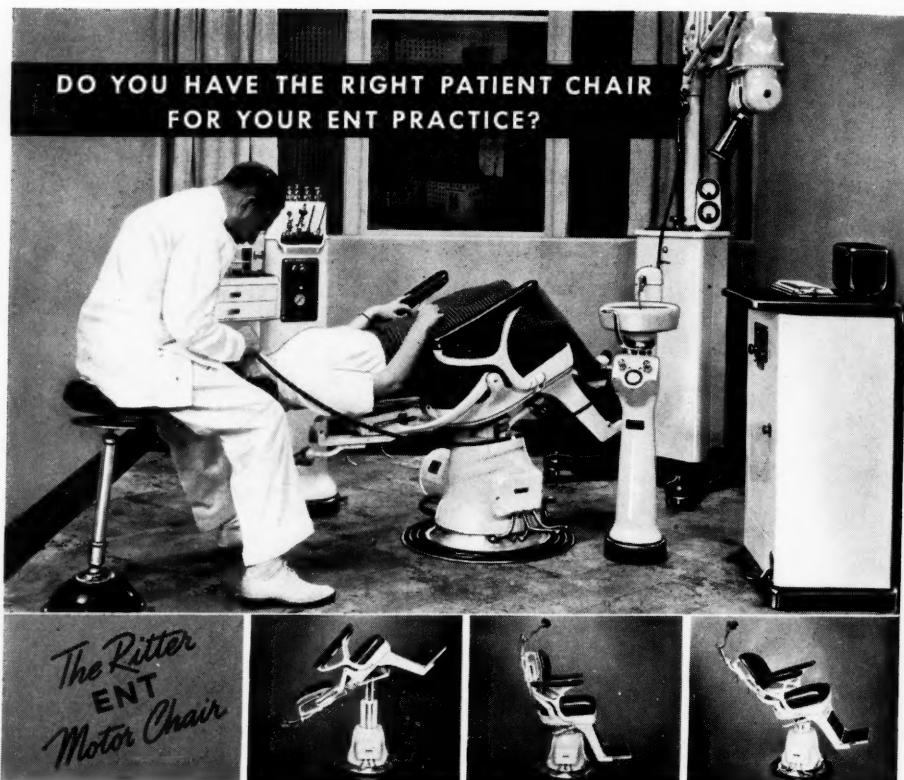
*Hinsie, Leland E.: *The Person in the Body, an Introduction to Psychosomatic Medicine*, New York, W.W. Norton & Co., 1945, p. 223.

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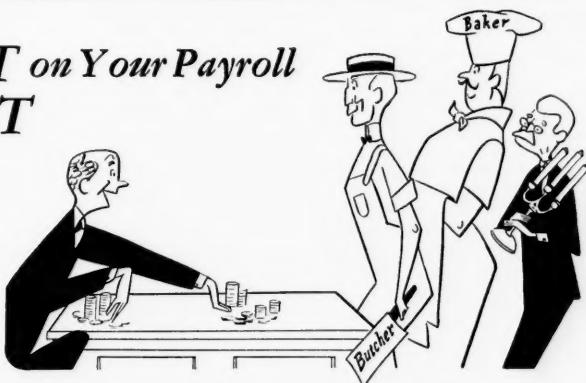
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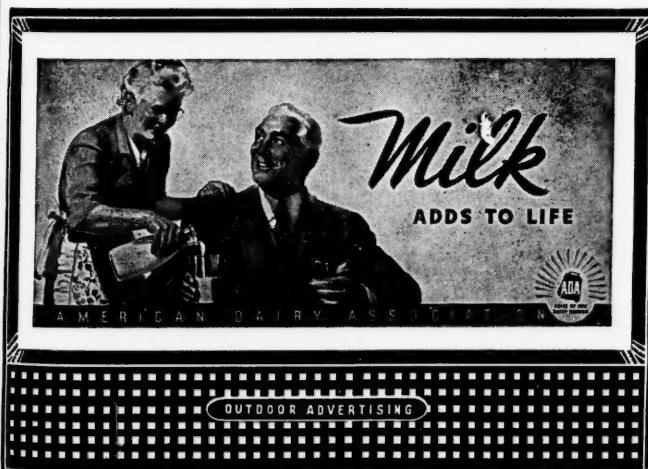
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Protein as a Therapeutic Factor In Infectious Disease

In the recent past, increasing attention has been called to the influence of severe infections upon protein metabolism and the profound destruction of tissue and serum protein which occurs in these states.^{1, 2}

In many instances, prompt control of infection by sulfonamides or penicillin is not followed by the desired degree of systemic improvement. Instead, protracted, stormy convalescence supervenes. A factor which is often responsible for delayed recovery is known to be the intense protein depletion which not only accompanies but also follows in the wake of infectious disease. Not infrequently, recovery can be sharply hastened by correction of existing nutritional deficiencies, foremost among them, protein deficiency. A protein intake, adequate both qualitatively and quantitatively, thus gains increasing significance as an integral part of therapy whenever the condition under treatment is known to lead to increased nitrogen excretion.

Among the protein foods of man meat ranks high, not only because it is rich in complete, biologically adequate protein, but also because its palatability and the many attractive ways it can be prepared make it acceptable to most patients.

¹ Tillett, W. S., Cambier, M. J., and McCormack, J. E.: The Treatment of Lobar Pneumonia and Pneumococcal Empyema with Penicillin, Bull. New York Acad. Med. 20:142, March, 1944.

² Armstrong, S. H., Jr.; England, A. C., Jr.; Favour, C. B., and Scheinberg, I. H.: Anemia and Hypoproteinemia Complicating Severe Protracted Pneumonia: Treatment with Penicillin—Role of Specific Supportive Therapy in Recovery, J.A.M.A. 127:303 (Feb. 10) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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